Building Trust, Addressing Burnout, and Expanding the Direct Care Workforce



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Building Trust, Addressing Burnout, and Expanding the Direct Care Workforce

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Executive Summary

The COVID-19 pandemic, which has claimed more than 1 million American lives as of September 2022, taxed the US public health system and shined a bright light on areas for improvement. This report addresses three areas the ACICBL has identified as being critical to supporting the health of individuals and clinicians nationwide: clinician burnout, the patient-clinician relationship, and Community Health Workers.

The demands of the pandemic physically, psychologically, and logistically overwhelmed many clinicians leading to high levels of burnout. Clinician burnout is associated with insomnia, anxiety, depression, and increased risk for substance use and misuse. Burnout implications extend to the institutional level where studies show that burnout is associated with increased medical errors, lower quality of care, and hospital-acquired infections. Burnout can be complex and multi-factorial, and thus requires a systems-oriented approach to address its root causes.

Patient trust in the public health care system and its clinicians is crucial for the delivery of care, especially during a national emergency. Such trust was certainly challenged during the pandemic. Facts about COVID-19 had to compete with a mischaracterization of the disease, false medical cures, contradictory health messages, an overwhelmed health care system in many areas, and even conspiracy theories. A lack of trust can result in the patient withholding important clinical information, delaying interaction with the system, and impact adherence with therapy and the plan of care. Understanding trust in the health care context is therefore crucial, as it is seen by many health care professionals as the keystone of the clinician-patient relationship.

Lastly, a growing body of evidence shows that Community Health Workers can improve health outcomes, produce cost savings, and address health disparities. Community Health Workers are trusted by the communities they serve and are critical in assisting in care, providing factual information, and dispelling misinformation related to health topics such as COVID-19 infection, symptoms, and vaccination. Finding ways to augment this workforce while also supporting other direct care workers, such as certified nursing assistants, home health aides, personal care aides, caregivers, and companions, in innovative ways can help the system prepare for future challenges.

Clinician Burnout

What is Clinician Burnout?

Burnout can mean different things to different people, as a universally accepted definition of burnout does not yet exist. However, it is generally accepted that burnout goes beyond simply feeling tired or experiencing chronic stress. While burnout can be associated with mental illnesses—such as anxiety and depression—it is also not a mental health diagnosis *per se*. So, what then is clinician burnout?[1]

In 1981, researchers Christina Maslach and Susan Jackson from University of California, Berkley published *The Measurement of Experienced Burnout*, which introduced the Maslach Burnout Inventory (MBI).[2] They defined burnout as being a mix of a "psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment."[3,4,5] Emotional exhaustion was further defined as the depletion of emotional resources; depersonalization as the callous or dehumanized perception of others [i.e., cynicism]; and reduced accomplishment as feeling dissatisfied with one's job accomplishments.[6] Since then, the MBI has been widely used in research to assesses the level of burnout as low, moderate, or high for each of these three subscales. Resulting burnout subscales scores are not combined, but rather assessed individually.[7,8]

Various studies have shown that burnout impacts not only the clinician, but also creates a ripple effect across the system. At the clinician level, burnout can be associated with insomnia, anxiety, depression, increased risk for substance use and misuse, exhaustion, and feelings of isolation.[9] At the institutional level, studies have shown that burnout is associated with increased medical errors, lower quality of care, and hospital-acquired infections.[10] For example, in a study of 7,100 surgeons, burnout was an independent predictor of reporting a major medical error.[11] Other studies have shown a link between increased emotional exhaustion in intensive care units and standardized patient mortality ratios.[12]

At the health care system level, burnout can lead to clinician shortages, decreased patient satisfaction, and increased staff replacement costs.[13] Annual system turnover costs are estimated to be between $2.6 and $6.3 billion for physicians and $9 billion for nurses.[14] Because of this ripple effect, clinician burnout has emerged as a public health priority.

Burnout Prevalence

The impact of burnout is exacerbated by the fact that burnout *is not* a rare event. In 2019, the National Academy of Medicine (NAM) published its seminal report *Taking Action Against Clinician Burnout*, which stated that at the time 35 to 54% of US physicians and nurses had substantial burnout symptoms.[15] Other studies have revealed that burnout among physicians and

nurses is *higher* than that in the general population. For example, physicians showed a higher rate of exhaustion (43.2%) and depersonalization (23%) compared with the general population in one study (24.8 and 14%, respectively). For nurses working in in-patient settings, another study showed that 18% had depression, compared with 9% in the general population.[16]

Burnout is also present among behavioral health professionals. A 2021 survey of 1,141 psychologists conducted by the American Psychological Association showed an increase in their treatment of anxiety disorders, depressive disorders, and trauma-stress related disorders during the pandemic. Psychologists also reported an increased workload and longer waitlists, suggesting that some may be working beyond capacity. Of the psychologists surveyed, 46% reported feeling burned out and more than half had turned to their peers for support with burnout.[17]

Most concerning is that burnout is not only present in clinicians who have been practicing for many years. Burnout is experienced even *before* clinicians enter the workforce. A 2012 study of nearly 4,400 medical students, 1,700 residents/fellows, and 7,200 early career physicians (defined as 5 or less years in practice) found that more than 55% of medical students, 60% of fellows, and 51% of early career physicians were burned out.[18]

Studies of physician burnout have also been done based on specialty. A study of more than 20 medical specialties showed that the highest burnout rates were in those at the front line of care. Family medicine, general internal medicine, and emergency medicine physicians had some of the highest levels of burnout among all specialties.[19]

Addressing Burnout

Individual-level strategies—such as mindfulness, taking breaks, stress management, balancing workload, yoga, and taking days off—may be helpful to some individuals, but do not by themselves address clinician burnout at its root cause. There is now recognition that the responsibility for burnout needs to go beyond the clinician and also include organizational and other external factors, such as organizational factors, the practice environment, and socio-cultural factors. In other words, it is important to think of clinician burnout as a multi-factorial issue with causes that go beyond only the clinician.[20,21]

The 2019 NAM report declares in its preface that it has two major themes: "First, that clinician burnout is a major problem…and Second, [that] the report recommends a systems approach to reducing clinician burnout."[22] The 2022 Surgeon General's Advisory on Building a Thriving Health Workforce—*Addressing Health Worker Burnout*—makes a similar assertion: "While addressing burnout may include individual-level support, burnout is a distinct workplace phenomenon that primarily calls for a prioritization of systems-oriented, organizational-led solutions."[23]

In 2017, researchers surveyed 252 individuals in 25 professions, including clinicians, about occupational stressors. Nearly 90 percent of them felt that stress and burnout were an issue in their profession. However, when asked about the primary cause of stress, their responses varied. Among their answers were: workload, staffing issues, work demands, leadership issues, high expectations, and documentation requirements.[24] Many of these factors are outside of the clinician's control.

Researchers concluded that "While it is indisputable that the nature of the work in health care causes stress, organizations also bear responsibility for accepting and even creating an institutional culture where stress can be worsened …" Researchers further suggested that "stress, anxiety, and depression leading to burnout, suicide, or other unhealthy behaviors do not stem from a single source but rather are the culmination of multiple forces…"[25]

The National Academy of Medicine has created a conceptual model, presented in Figure 1 below, that reflects the contributing factors affecting clinician resilience and well-being. The model is flexible and can be applied to various disciplines, career stages, and settings. It begins with the patient well-being at the center, as without a patient there is no clinician. At the outer ring are both the individual (in blue) and external factors (in yellow). Most of the model's burnout factors—such as organizational factors, practice environment, and socio-cultural factors—are external. This is an important recognition that clinicians alone may not always be able to change an external factor, especially in large health care systems.[26]

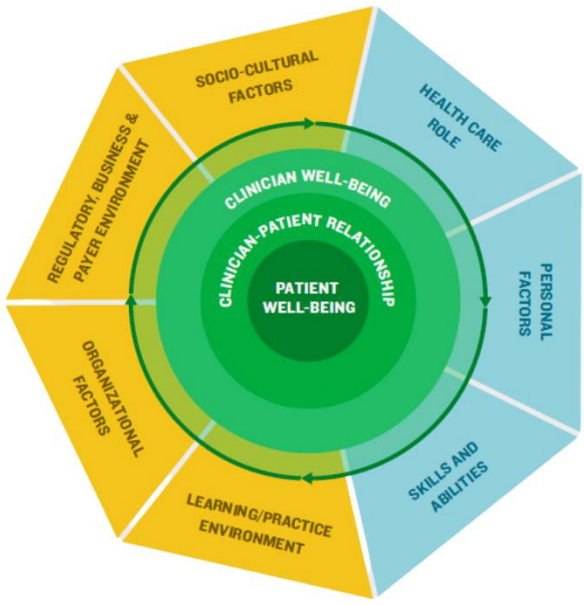


Figure 1. The National Academy of Medicine's Conceptual Model of Factors Affecting Clinician Well-Being and Resilience (Source: National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience, 2018.)

In summary, both the developers of the above conceptual model and the recent Surgeon General's report agree that burnout and clinician well-being are complex and multi-factorial, and require a systems-oriented approach to address its root causes.[27,28]

Exemplary Programs

In 2011, The Ohio State University (OSU) was the first US university to appoint a Chief Wellness Officer and in 2018 the University's Board of Trustees approved its first Health and Wellness Strategic Plan, which covers not only the university's hospitals but also students, staff, and other populations. The plan supports evidence-based programming, practices, and interventions to reduce population health risks and consistently engage staff in health behaviors to attain their highest levels of well-being. It takes a multi-component, evidence-based approach with a focus on institutional culture and measurement of outcomes. The plan includes a list of more than 30 SMART (Specific, Measurable, Achievable, Realistic, and Time-Bound) objectives along with metrics used to assess them.[29]

The strategic plan is systemic and relies heavily on changing the institution's culture and engaging management, leadership, and the system as a whole. Through this plan, OSU has developed a University Health and Wellness Council. The Council is a permanent structure chaired by University Vice Presidents that includes directors, chairs, and other leaders from various departments. It meets once a month to discuss wellness efforts and other related issues.

One of the initiatives at OSU is Buckeye Paws. It was launched in March 2020, with the mission of supporting the mental and emotional health of staff by using trained, certified therapy dog-handler teams. The dogs meet and interact with clinicians at the clinician's workplace during short breaks. One individual remarked that a dog's presence can "calm people, brighten their mood, and allows them time to decompress, even if only for a quick moment."[30]

Another OSU program is MINDBODYSTRONG. It is an evidence-based program to improve clinician well-being. The program consists of seven weekly sessions (35-45-minutes each) led by a trained facilitator. The aim of the program is to improve mental health and equip individuals with skills that have been shown to enhance healthy lifestyle behaviors. Backed by 20 studies, program participants demonstrated a significant reduction in stress, anxiety, depressive symptoms, and suicidal ideation after course completion.[31] An additional component for improving clinician well-being may include companies limiting email access and committing to employee well-being at the highest leadership levels.[32,33]

Dr. Lorna Breen's Story: A Cautionary Tale

While not all stories of clinician burnout are as extreme as Dr. Lorna Breen's, her story is nonetheless a cautionary tale about the importance of addressing clinician burnout.

Dr. Breen was a physician at an emergency room in a Manhattan hospital. Well respected by her colleagues, she appeared to many as unflappable. She was an ivy league graduate and ran half-marathons on her spare time. At the start of a half-marathon, she felt she had trouble breathing, but continued running nonetheless. When she finished the race, she diagnosed herself with a pulmonary embolism and checked into a hospital.[34]

Despite her grit, Dr. Breen did not expect the high level of stress and burnout that accompanied the pandemic. The hospital was overcrowded and patients lay in the hallways. At her hospital there were not enough beds, supplies, or staff at times.[35,36] She worked long days. Even after recovering from a COVID-19 infection herself, she continued to tend to patients, but felt there were too many of them she could not save. Despite all of these obstacles, she did not want to ask for help because she thought the stigma could hurt her career.[37]

One day, Dr. Breen called a friend and said she could not get out of her chair. Her friend noticed that Dr. Breen had a hard time answering simple questions. Her sister eventually convinced her to check into a psychiatric ward where she spent 11 days. Unfortunately, sometime after she was discharged, she died by suicide. While it might be difficult to determine all the reasons behind it, it would be hard to ignore the stress of the pandemic as a contributing factor.[38]

In March 2022, President Biden signed the Dr. Lorna Breen Health Care Provider Protection Act, which aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals. The bill will help promote mental and behavioral health among clinicians and supports burnout prevention training for health professionals.[39,40]

The Patient-Clinician Relationship

Trust and the Public Health Care System

In 2021, as the COVID-19 pandemic was striking the nation, the school of public health at Harvard University conducted a national survey on people's perspective of the US public health system. The resulting report showed that, overall, the public placed higher trust on doctors and nurses than in several public health institutions. Of those surveyed, 71% said they trusted nurses and 67% trusted doctors "a great deal or quite a lot" with respect to recommendations made to improve health. However, only 52% trusted the CDC, 37% trusted the NIH, and 33% the US Department of Health and Human Services to make similar recommendations.[41]

Trust in the health care system is crucial for the effective delivery of care. A lack of trust can result in the patient withholding important clinical information, delaying interaction with the system, and can impact adherence to therapy and the plan of care. Trust in public health institutions can also influence the consumer's trust of the information provided by those same institutions online.[42]

Institutional trust and clinician trust are not one and the same. While it can be influential, institutional trust does not automatically confer patient trust on all of the institution's clinicians.[43] Also, trust is not homogenous across patients. Studies show that trust levels can vary based on patients' ethnicity, race, sexual orientation, geography, and even political affiliation. As the Committee's recommendation in this report focuses on the clinician-patient relationship, the following section addresses trust in this relationship.[44,45]

Patient-Clinician Trust

Trust is at the center of the patient-clinician relationship. The American Medical Association's Code of Ethics Opinion states that "The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest ..."[46] Similarly, the Code of Ethics for Nurses sets forth that "The nurse's primary commitment is to the patient…"[47] For various health care professionals, trust is generally seen as the keystone of the clinician-patient relationship.[48]

Trust is a complex, multidimensional construct. Various definitions of trust in the health care context have been proposed by researchers. Those definitions have included various factors including communication, compassion, honesty, reliability, dependability, competence, and privacy.[49,50] Instruments to measure trust have been used by researchers in various academic disciplines (e.g., sociology, economics, psychology, and political science), including health care. Those instruments used to measure patient-clinician trust have generally varied across studies and have focused on either one or a combination of the above factors.[51,52] Some studies have found that two strong predictors of trust are the physician's personality and their behavior. In particular, patient trust has been consistently related to the physician's *communication style, interpersonal treatment, and knowledge of the patient.*[53,54]

In the area of communication, studies show that the way physicians communicate information can be as important as the information being communicated itself.[55] For example, physician competency in delivering bad news can impact patient "anxiety, depression, hope, decision making, and adjustment to illness."[56] Conversely, a review of randomized control trials in a variety of clinical settings and areas of practice suggests that effective communication can exert a positive influence on the patient's symptom resolution, pain control, emotional health, and

functional and physiologic status.[57] In addition, communication skills have been positively correlated with patient satisfaction.[58]

Trust, the Pandemic, and Underserved Communities

The COVID-19 pandemic placed a clear spotlight on the impact of health misinformation and disinformation on groups and individuals. A 2020 study by the Pew Research Center of 8,914 adults showed that nearly 3 in 10 Americans believed that the COVID-19 virus was created in a lab.[59] Misinformation about COVID-19 has been linked to negative outcomes such as willingness to comply with evidence-based health regulations and vaccine uptake intentions worldwide.[60]

During the COVID-19 pandemic, clinically accurate and factual information coexisted with a mischaracterization of the disease, false medical cures, contradictory health messages, and even conspiracy theories. These efforts politicized and undermined the response to the pandemic by the public health care system. They also resulted in increased infections, worse outcomes, and deaths. Some social media platforms greatly amplified inaccurate information, until measures were put in place to mitigate the spread of false content.[61,62]

The impact of false health information impacts individuals as well as the nation's economy. A study by the Center for Health Security at Johns Hopkins University estimates that nonvaccination due to misinformation and disinformation have caused between $50 and $300 million of harm *every day* since May 2021, when vaccines became freely available to most American adults. Most of the measured harm included the monetized value of morbidity and mortality, as well as financial harm (health care system costs and economic losses resulting from people missing work).[63]

While false information increased distrust by some individuals towards the public health system, some communities have held mistrust towards the public health care system and clinicians even before the pandemic.[64] Historical abuses such as not offering the standard available treatment (penicillin) to black men living with Syphilis who participated in the Tuskegee Syphilis Study;[65] using genetic material without appropriate consent from members of Arizona's Havasupai Tribe;[66] and the sterilization of Latinas living in California without their permission,[67] are but a few of the many historical examples of unjust practices perpetrated against underserved communities.

It is important to note that underrepresented communities are not homogeneous. Mistrust among underserved populations is not uniform, and can vary based on geographical location, education, income, and insurance status. The relationship between race and the US public health system is complex and overcoming some of the mistrust towards it may require efforts that are system-wide, institutional, and interpersonal.[68,69]

Community Health Workers

Community Health Workers

At the community-level, Community Health Workers (CHWs) are partners trusted by individuals to deliver various health-related services including health promotion, prevention, and treatment. While evidence shows that services provided by CHWs improve health outcomes,[70] there is less agreement on the definition of a Community Health Worker. One complication is that more than 100 job titles fall under the umbrella of a CHW.[71] Some of these include: community health educator, patient navigator, *promotor*, peer educator, public health aide, outreach worker, neighborhood health advisor, and maternal outreach specialist.[72] For the purposes of this section, direct care workers may also be included under the umbrella. In addition, CHWs can have a variety of roles, be lay or professionals, and be either paid or unpaid.[73,74]

One of the most accepted definitions by members of the CHW workforce is the one provided by the American Public Health Association, which defines a CHW as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[75,76]

Around the world, CHWs have participated in treating conditions such as diabetes, hypertension, tuberculosis, and HIV, among many others. CHWs have also been involved in preventive services such as cancer screening and public health promotion efforts such as breastfeeding, immunization, and safe sex initiatives. One of the most important assets of CHWs is the trust they have built with the community through cooperation, empathy, and open communication with those they serve. As a result, they can act as an effective liaison between the community and the public health system.[77]

Health Outcomes and Costs

In 2016, researchers from Harvard University and King's College London conducted a systematic review of studies involving CHWs and chronic conditions. Chronic conditions—those lasting a year or longer—impact 6 in 10 adults in the US, and are the leading drivers of death and disability. The review examined interventions for diabetes, asthma, hypertension, stroke, heart failure, HIV, and other conditions. Of the 34 studies meeting the eligibility criteria, 16 were randomized control trials, 8 pre/post studies, 6 cohort studies, and 4 cost-effectiveness analysis.[78,79]

Eleven studies showed a significant decrease in emergency department visits during or after the CHW intervention, relative to baseline. With respect to hospitalizations, of the 7 studies

measuring this variable, 6 showed a significant decrease in hospitalizations. Urgent care use was seen to decrease in 6 of the 7 studies reviewed. Results for the impact on medication use (adherence and preventable use) as well as outpatient visits to clinicians were mixed.[80]

In all studies, the CHW intervention was found to be low-cost (less than $1,500 annually per-patient/family), and for studies reporting overall costs the majority found the interventions to be cost saving.[81] A different study of CHWs working with Medicaid patients with diabetes in West Baltimore found that the use of CHWs produced *savings* of $2,200 per patient per year.[82] A different study found that CHW interventions led to a return of investment of $2.28 for every $1 dollar spent on the intervention.[83]

Another systematic review of 18 studies involving CHW interventions to increase rates of screening mammography found a statistically significant increase in screening rates. Other evidence shows that CHWs have been found to help address health care disparities in various communities, such as rural Indiana, which is predominantly White, as well as South Texas, a predominantly Spanish-speaking population.[84]

Growing the Profession

The body of evidence suggesting that CHWs can improve health outcomes, reduce cost savings, and address disparities supports the need to scale up the number of CHWs working with vulnerable populations nationwide. A projection developed by HRSA estimates that demand for CHWs will grow by 14% from 2016 to 2030. In other words, HRSA estimates that an additional 5,590 full-time CHWs will be needed by 2030 to meet demand. In 2022, the Biden-Harris administration took a step to meet this demand by allocating $226.5 million for HRSA to increase the number of CHWs.[85,86]

In separate efforts, nonprofit organizations, states, and other organizations have proposed their own strategies to improve the recruitment and retention of CHWs and decrease attrition in the field. These suggestions include: the development of certification programs, pipelines/career ladders, providing standardized training, improving compensation, providing a variety of incentives (financial and nonfinancial), and other strategies.[87,88,89]

One of the key difficulties involving training and the development of a career ladder is the large number of job titles and roles that exist under the CHW umbrella. To address this, the Community Health Worker Core Consensus (C3) Project released the publication *Together Leaning Toward the Sky* in 2018 which presents a list of comprehensive CHW roles, skills, and qualities vetted by CHW networks nationwide.

The document defines 10 roles and 11 skills for CHWs, regardless of work setting. Some of the roles include: providing culturally appropriate health education, care coordination, system

navigation, advocating for individuals, and providing direct service. Defined skills include: communication, capacity building, advocacy, outreach, education, and others. At least 20 state policy initiatives have used the C3 Project recommendations as a starting point for their deliberations on their own CHW definitions and policies.[90]

Exemplary Programs

IMPaCT

The Penn Center for Community Health Workers, located within the University of Pennsylvania, has developed an evidence-based model for a health program involving CHWs and low-income patients. The program, called (IMPaCT)—Individualized Management for Patient-Centered Targets—is meant to be used across health systems and chronic diseases. In a randomized controlled trial IMPaCT was found to improve access to primary care and quality of discharges in a high-risk population. The IMPaCT model includes five program elements: 1) Hiring guidelines to decrease CHW turnover, 2) Clear policies and procedures to promote productivity, 3) Patient-centered care to allow for scalability, 4) Integration of CHWs into health care teams for effective communication, and 5) High-quality scientific evidence to validate results. This evidence-based model is documented and includes 9 manuals to support implementation by other organizations.[91,92]

CROWD

The Sinai Urban Health Institute (SUHI) created CROWD (Center for CHW Research, Outcomes, & Workforce Development). SUHI has been employing CHWs for chronic disease management for more than 20 years. Based on their experience, they have developed the publication *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings* as well as a series of training videos. Their model addresses barriers to CHW recruitment, training, supervision, and other matters. Since its inception, CROWD has collaborated with 56 organizations to integrate the CHW model and trained more than 1,700 CHWs.[93,94,95]

Summary

This report addresses three areas the ACICBL has identified as being critical to supporting the health of individuals and clinicians nationwide: clinician burnout, the patient-clinician relationship, and CHWs.

The COVID-19 pandemic showed that health care institutions need to focus on both serving patients and the clinicians that serve them. Failure to do so can lead not only to clinician burnout, but cause a wider impact across the system, as studies have shown that burnout is associated with increased medical errors, lower quality of care, and increased turnover costs. The body of evidence makes it clear that burnout is not solely the responsibility of the clinician. Burnout is a multi-factorial issue that requires a systems-oriented approach to address its root causes.

Studies have also shown that patient-clinician trust can be an important factor for the effective delivery of care. The pandemic placed a clear spotlight on the impact of health misinformation and disinformation on groups and individuals. Misinformation and disinformation resulted in increased infections, worse outcomes, and deaths. Therefore, strengthening trust in clinicians and institutions could help to positively impact health outcomes for Americans nationwide.

Finally, various studies show that the one-on-one involvement of CHWs can improve health outcomes, reduce cost savings, and help address disparities in vulnerable populations. Programs that have been found effective in increasing the recruitment and retention of CHWs—along with other national efforts such as CHW career ladders, standardized training, and improved incentives—can make a difference in the health of individuals in vulnerable communities.

The recommendations presented in this report help shore up these three important areas at a national scale to develop a stronger, healthier, and more effective future workforce to serve all Americans.

List of Acronyms and Abbreviations

ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
BHW	Bureau of Health Workforce
CHW	Community Health Worker
MBI	Maslach Burnout Inventory
NAM	National Academy of Medicine
NOFO	Notice of Funding Opportunity
OSU	The Ohio State University

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