**Addressing Provider Burnout with Peer Support Groups: A Quality Improvement Project**

Marisa A. Arana, Teri A. Bartlow

School of Nursing, Oregon Health & Science University

NURS 703B: DNP Project

March 11, 2025

Submitted to: Dr. Rodney Olin DNP – Chair

**Table of Contents**

# Abstract

**Background:** Occupational burnout is a widespread phenomenon among healthcare providers, particularly those in psychiatric emergency settings. This project aim was to reduce provider burnout. The setting was the psychiatric emergency services (PES) in an urban psychiatric hospital; participants were recruited from the 29 psychiatric providers on the unit.

**Methods:** The Plan-Do-Study-Act (PDSA) method was used for this quality improvement project. The Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP) tool was utilized alongside a cognitive burden survey.

**Intervention:** Provider Peer Support Groups were created based on Schwartz Rounds and Balint Groups. Groups consisted of 40–60-minute case discussions that provide a structured forum for providers to reflect on the emotional and psychological aspects of patient care. The intervention was implemented in three PDSA cycles.

**Results:** With participation rates of 3.33%, 0%, and 6.9% across the three PDSA cycles, data could not be gathered or evaluated without compromising participant confidentiality. Qualitative data gathered from participant discussion and feedback revealed themes—such as frustration, hopelessness, moral distress, guilt, and compassion fatigue—and offered insights to improve future QI projects in this setting.

**Conclusion:** Low participation prevented effective implementation of this project. Qualitative findings highlight the need for structurally embedded, time-limited, and easily accessible burnout interventions in psychiatric settings.

**Keywords:** Burnout, peer support, MBI-HSS, quality improvement

**Introduction**

**Problem Description**

Maslach and Jackson (1981) conceptualize occupational burnout as a syndrome encompassing three domains: 1) emotional exhaustion, which involves feelings of depletion, overwhelm, and fatigue; 2) depersonalization, which entails cynicism and/or detachment toward patients, colleagues, and work; and 3) low levels of personal accomplishment, including decreased feelings of competency, achievement, and effectiveness. Burnout is a pervasive risk among psychiatric providers such as psychiatric mental health nurse practitioners (PMHNPs) and psychiatrists (Johnson et al., 2018). The estimated national prevalence of burnout in mental health providers is between 21 and 61 percent (American Psychological Association, 2018). Although Oregon-specific data on provider burnout is unavailable, Edge (2023) asserts that personnel shortages in the state significantly exacerbate clinician burnout. Furthermore, providers working within the emotionally charged, high-stakes environment of psychiatric settings are particularly prone to burnout (Liu et al., 2019; O'Conner et al., 2018).

Occupational burnout has important implications for psychiatric providers and the patients they care for. Individually, mental health workers facing burnout are more likely to experience: psychiatric illness (Ham et al., 2022; Li et al., 2021; Seto et al., 2020); cognitive impairment (Koutsimani et al., 2021; Schmidt et al., 2021); and physical symptoms and diseases (Salvagiani et al., 2017). Organizational outcomes associated with burnout include absenteeism, reduced productivity, reduced organizational loyalty, reduced job satisfaction, medical error, and increased turnover (Maslach & Leiter, 2016). For patients, burnout translates to lower quality of care and increased morbidity and mortality (Garcia et al., 2019).

**Available knowledge**

To synthesize the available knowledge on psychiatric provider burnout, a literature search was conducted in PubMed and PsychINFO using the following key terms: 'burnout', 'psychiatrists', 'mental health workers', and 'psychiatric providers'. Results were further narrowed down by relevance and a timeframe of the last decade with the exception of seminal articles.

Occupational burnout is a complex, multifaceted phenomenon caused by individual, organizational, and systemic factors. Related organizational factors include lack of leadership or supervision, role ambiguity, poor coordination of care, staffing shortages or poor staff-patient ratios, high workload, and occupational failures (SAMHSA, 2022). Providers in the intense and high-pressure environments of emergency and psychiatric settings are particularly susceptible to burnout due to their frequent exposure to emotionally charged and traumatic situations, as well as instances of violence or verbal abuse from patients and their families (Maslach & Leiter, 2016). Additional contributing factors include broader systemic issues related to access to care, resource allocation, funding, and healthcare policies or regulations, particularly in the context of the COVID-19 pandemic (National Academies of Sciences, Engineering, and Medicine, 2019).

Interventions for burnout can be broken into two categories: organizational-level and individual-focused interventions (Zhang et al., 2020). Organizational interventions focus on systemic factors. Some organizational interventions seek to improve existing culture and practices through methods such as employee recognition, clinical supervision, alteration of workload and schedule rotation, and integration of trauma-informed care philosophies (Dawson-Rose et al., 2023; Elisseou, 2023; Musker & Othman, 2024; Zhang et al., 2020). Other organizational approaches utilize evidence-based programs designed to provide support for employees. Schwartz Rounds and Balint Groups in particular have been found to improve

burnout (Allen et al., 2020; McLean et al., 2023; The Schwartz Center, 2024). Individual-level interventions address burnout through personal and professional skill development and the promotion of overall wellness. Examples of individual interventions include mindfulness-based education, self-care workshops, stress management and resiliency training, yoga, meditation, massage, and communication skills training (Bekelepi & Martin, 2022; Zhang et al., 2020).

**Rationale**

This project utilized the Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI). Founded in 1991 by Dr. Donald Berwick, IHI is a non-profit organization with global recognition for innovative approaches to healthcare improvement (Berwick, 2008). The MFI uses Plan-Do-Study-Act (PDSA) cycles to implement changes in real-world clinical environments in a step-wise, iterative fashion (2009). The MFI is a renowned guide for quality improvement projects, widely utilized by healthcare systems (Langley, 2009).

The root cause analysis (see Appendix A for cause-and-effect diagram) identified insufficient organizational support, particularly the under-utilization of existing peer support efforts, as a major factor contributing to burnout among PES providers. To bridge this gap, the project implemented an organizational intervention combining elements of evidence-based peer-support interventions. A literature review demonstrates the effectiveness of organizational interventions based on the principles of peer support as a part of trauma-informed care (Elisseou, 2023; SAMHSA, 2022; Wampole & Bressi, 2019). The Schwartz Center Rounds have been shown to benefit healthcare provider burnout through improvements in mental and emotional well-being (Maben et al., 2018; Ng et al., 2023; Whitehead et al., 2021); organizational culture, teamwork, and interprofessional relationships (Allen et al., 2020); and empathy and compassion for patients (Allen et al., 2020; Hogan et al., 2022). Balint Groups have been found to improve

provider self-concept—increasing feelings of confidence, comfort, self-esteem, and competence—as well as patient-provider interactions (Kannai et al., 2024; Mahoney et al., 2013). The substantial evidence indicated a promising intervention to reduce burnout among PES providers.

**Specific Aims**

By the end of November of 2024, there would be an overall reduction in the perception of burnout for providers in the PES. Participating providers' scores on the Maslach Burnout Inventory Human Services Survey for Medical Professionals (MBI-HSS MP) subscales would improve by 10% in response to Provider Peer Support Groups.

## Methods

**Context**

Located on the first floor of a psychiatric hospital in Portland, the PES operates as the sole psychiatric emergency department in Oregon, serving patients from across the state. While the PES is licensed for 50 beds, maintaining the required staff-patient ratio of 1:5 puts the maximum patient census at 35 (Norton, 2024). Patients in the PES receive prompt psychiatric evaluation and stabilization. They are then triaged for discharge to the community, transfer to other psychiatric facilities, or admission to one of the hospital's 84 adult inpatient beds or 22 pediatric inpatient beds. According to 2023 data, the PES had a total of 10,437 patient visits annually, with an average of 28.6 daily visits (Norton, 2024). There are 29 psychiatric providers in the PES which includes both PMHNP's and psychiatrists.

Several systemic factors causing strain on local and state mental health systems provide important context. Oregon's mental health system is severely understaffed: nearly a quarter of unfilled positions in the field, meeting only one-third of Oregon's mental health needs (Edge,

2023; Kaiser Family Foundation, 2024). Lack of community and outpatient mental health infrastructure forces patients to seek care in emergency settings and those discharged from the PES or inpatient units have difficulty obtaining adequate follow-up care, perpetuating a cycle of repeated crisis presentations. Furthermore, a 2022 ruling by the Federal District Court mandated Oregon State Hospital (OSH)—the largest public state psychiatric hospital—to abide by the 2002 Mink Order, which requires OSH to admit aid-and-assist patients within seven days (Oregon Health Authority, 2022). The influx of aid-and-assist patients led to less availability for civilly committed patients, resulting in the clinical site hospital taking on these more high-acuity patients. These factors were exacerbated by the COVID-19 pandemic (Leo et al., 2021).

**Intervention**

The Peer Support Group—a structured forum where providers discuss and reflect on the emotional and psychological aspects of patient care—was developed based on the best evidence from two previously established models, Balint Groups and Schwartz Center Rounds. Peer Support Groups were 40-60 minute, meetings consisting of 2-8 attendees. Each meeting was led by a facilitator, who went over the format, purpose, and ground rules of the meeting (see Appendix G). The facilitator then presented a de-identified patient case for the first ten minutes. The remaining time was open group discussion. Sample questions were used to guide the discussion (see Appendix G). PES providers were invited by email one month prior, with follow up emails sent one week and one day prior. This intervention was given in three Plan-Study-Do-Act (PDSA) cycles, scheduled several weeks apart from October to December 2024.

**Study of the Intervention**

The Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP), was selected to evaluate the effectiveness of the intervention (Bykov et al., 2022;

Forné & Yuguero, 2022; Ham et al., 2022; Pereira et al., 2021; Rotstein et al., 2019; Tang et al., 2023). The MBI-HSS (MP) is a 22-question self-report questionnaire where respondents rate the frequency of burnout-related feelings or experiences on a 7-point Likert scale (see Appendix B for sample questions). Results are scored across three dimensions: Emotional Exhaustion, Depersonalization, and Personal Accomplishment (Maslach et al., 1997). A license to administer fifty copies of the MBI-HSS (MP) within three years was obtained on June 9th, 2024 from Mind Garden, INC (see Appendix B). Participating PES providers in Peer Support Groups were to be given two copies of the MBI-HSS to complete anonymously, both before and after the intervention. The post-intervention MBI-HSS (MP) also included additional questions to evaluate cognitive burden (see Appendix C). Scores were to be measured using the scoring keys for each subscale (see Appendix D) and compared to normative data (see Appendix E).

**Measures**

The primary outcome measure of this project was the average change in *individual* participants' subscale scores of the MBI-HSS (MP) before and after Peer Support Groups. Lower scores on Emotional Exhaustion and Depersonalization, along with higher scores on Personal Accomplishment, are indicative of lower levels of burnout (Maslach et al., 1997). The secondary outcome measure is average change in subscale scores of the MBI-HSS (MP) for each *group* of participants in each PDSA cycle. The project aim was to achieve at least a 10% post-intervention improvement in scores for both individual respondents and each group. These measures would have enabled the assessment of whether the intervention resulted in improvements across these three domains of burnout.

The primary process measure is the percentage of PES providers that participated in the Peer Support Groups. The balancing measure was the perceived cognitive burden of participating

providers. The balancing measure was assessed via a Likert scale survey with an option for additional commentary (See Appendix C).

**Analysis**

The study design included collecting and recording participant data in Microsoft Excel version 16.69.1. Both individual-level and group-level analyses were intended. Individual scale scores were to be calculated using the summation (SUM) and average (AVE) method. The SUM would have added items from each scale to create an overall scale score for comparison to normative data, while the AVE was meant to calculate the mean response for the items that made up each subscale (see Appendix F) (Maslach et al., 1997). To compare pre- and post-intervention group scores, sample means ($\bar{x}$) and standard deviations (SD) were to be calculated in Excel. A Wilcoxon Signed-Rank Test was planned to measure and compare the medians of paired samples using SPSS. A p-value less than 0.05 was to be considered significant.

**Ethical Considerations**

Because this quality improvement (QI) project utilized data-driven methodology to improve healthcare delivery and quality within a specific organization, it did not constitute human subjects research and thus fell outside the scope of regulations for the protection of human subjects (45 CFR part 46) (Bass et al., 2020; United States Department of Health and Human Services, n.d.). This project did not involve patient participation, interaction, or identifiable data. Voluntary participation in this project was for employed staff of this organization, including Dr. Rodney Olin, DNP, who was both a provider working in the PES and the project chair. Staff responses to questionnaires and surveys remained anonymous, ensuring privacy and confidentiality. Initial involvement in this project did not obligate participants to continue in subsequent stages. The primary ethical considerations in this project were the

cognitive and time burdens placed on staff. To address this, all interventions were time-limited and feedback was gathered.

## Results

The project was carried out using three PDSA cycles between October and December 2024 (see Appendix N). During PDSA Cycle 1, email invitations were sent to all 29 PES providers one week prior, offering complimentary food and beverages to attendees of the meeting. The first Peer Support Group was held in a hospital conference room and had a participation rate of 3.33% (1 out of 29 providers). Though a group case discussion occurred (see Appendix H), the MBI and cognitive burden surveys were not administered to protect the confidentiality of the participant. Notes were recorded to gather qualitative data (Appendix K).

To encourage greater participation in PDSA Cycle 2, the second group was held virtually via Microsoft Teams. The MBI and cognitive burden surveys were converted into Google Forms with a shareable link. In lieu of complimentary food and beverages, participants were entered in a raffle to win an equivalent-value gift card. This raffle was advertised in the invitations sent one week prior. The participation rate for the second Peer Support Group was 0%.

To encourage participation in PDSA Cycle 3, 15 promotional posters (see Appendix J) were displayed in PES staff areas one week prior. Email invitations were sent to providers' primary and secondary email addresses one week in advance, with text message invitations sent a week prior and a reminder text the day before. The third Peer Support Group meeting yielded a participation rate of 6.90% (2 out of 29 providers). Notes were taken during the group, and participants provided feedback on ways to enhance future efforts with this intervention. Due to technical difficulties preventing one participant from accessing the surveys on Google Forms, the surveys were not administered to maintain the confidentiality of the participants.

PDSA Cycles 1 and 3 case discussions provided qualitative insights, captured through participant quotes (Appendix K). Participants expressed "frustration" over managing difficult patient situations, particularly those involving frequent patient presentations and violence against staff. They discussed shared feelings of "guilt" for being unable to meet patient needs and balancing the needs of patients and colleagues. They described feelings of hopelessness, particularly regarding patient prognosis or ability to make an impact, with participants questioning, "what's the point?" or feeling as though "there's nothing we can do to help." One provider expressed difficulty maintaining the level of compassion and empathy they had earlier in their career.  Additionally, participants offered suggestions for improvement of future burnout interventions (Appendix K).

## Discussion

### Summary

With participation rates of 3.33%, 0%, and 6.9% across the three PDSA cycles, our outcome measure—individual and group participant subscale scores on the MBI-HSS—and our balancing measure—perceived cognitive burden—could not be evaluated without compromising participant confidentiality. Despite implementing evolving strategies to boost attendance, it remained low. Although survey data could not be collected, qualitative insights were collected by writing down quotes and verbal feedback of participants.

### Interpretation

This project did not achieve its initial goal of reducing PES providers' perception of burnout. Due to low attendance across all three PDSA cycles, MBI-HSS MP and cognitive burden survey data could not be collected or analyzed to assess the intervention's impact. However, qualitative data (Appendix K) was informally gathered and analyzed, offering valuable

insights into the nature of provider burnout. Themes identified from provider quotes during the case discussion segments of PDSA Cycles one and three included frustration, hopelessness, moral distress, guilt, and compassion fatigue. These themes are frequently identified in the literature as hallmark indicators of burnout and align closely with the Maslach Burnout Inventory (MBI) subscales: Emotional Exhaustion, Depersonalization/Cynicism, and Reduced Personal Accomplishment (see Appendix B). This alignment suggests that participating providers were experiencing burnout.

Additionally, participants offered recommendations for addressing burnout with ideas for future interventions, including integrating support groups into existing workflows (i.e., mandated staff meetings), utilizing mindfulness apps, and implementing brief, impromptu debriefings among colleagues. These suggestions indicate that key barriers to participation in this intervention included its lack of integration into existing workflows, reliance on voluntary participation, and time constraints.

**Limitations**

Several limitations were identified during the implementation of this project. The primary limitation of this study was its method and design, as the intervention was not realistically adaptable to this context due to the time commitment required for the intervention, paired with the high workload burden and competing priorities. Despite multiple strategies to enhance participation, poor attendance hindered data collection and analysis. A between-subjects design was chosen for feasibility, but may not fully capture the intervention's impact on burnout, as its effects may not be immediately evident. A repeated-measures, within-subjects design would better assess burnout over time and cumulative effects. Regarding data limitations, the qualitative data was derived from only 3–6% of the total PES provider population, which limits the

generalizability of the findings. Additionally, the thematic analysis lacked a structured qualitative process, with themes identified informally. This approach introduces the potential for author bias in theme selection and interpretation, further impacting the validity of the results.

**Conclusions**

Burnout is a widespread issue among healthcare workers, particularly in psychiatric emergency settings. While existing literature supports the effectiveness of organization-wide peer support interventions, this QI project was unable to demonstrate the impact due to low participation. Despite not achieving its intended outcomes, qualitative findings underscore the need for burnout interventions that are structurally embedded, time-limited, and easily accessible. Future research should refine study design to improve data validity and enhance feasibility by integrating interventions existing workflows and leveraging technology-based solutions like mindfulness apps. Ultimately, addressing burnout is essential not only for provider well-being but also for delivering high-quality patient care.

# References

Allen, D., Spencer, G., McEwan, K., Catarino, F., Evans, R., Crooks, S., & Gilbert, P. (2020). The Schwartz Centre Rounds: Supporting mental health workers with the emotional impact of their work. *International Journal of Mental Health Nursing, 29*(5), 942–952. https://doi.org/10.1111/inm.12729

American Psychological Association. (2018). *Research roundup: Burnout in Mental Health Providers.* https://www.apaservices.org/practice/update/2018/01-25/mental-health-providers

Bass, P. F., 3rd, & Maloy, J. W. (2020). How to determine if a project is human subjects research, a quality improvement project, or both. *Ochsner Journal*, *20*(1), 56–61. https://doi.org/10.31486/toj.19.0087

Berwick, D. M. (2008). The science of improvement. *JAMA*, *299*(10), 1182. https://doi.org/10.1001/jama.299.10.1182

Bykov, K. V., Zrazhevskaya, I. A., Topka, E. O., Peshkin, V. N., Dobrovolsky, A. P., Isaev, R. N., & Orlov, A. M. (2022). Prevalence of burnout among psychiatrists: A systematic review and meta-analysis. *Journal of Affective Disorders*, *308*, 47–64. https://doi.org/10.1016/j.jad.2022.04.005

Edge, S. (2023, October 21). *Oregon's mental health workforce 'crisis' exacerbates challenges finding care.* The Oregonian/OregonLive. https://www.oregonlive.com/health/2023/10/oregons-mental-health-workforce-crisis-exacerbates-challenges-finding-care.html

Elisseou, S. (2023). Trauma-informed care: A missing link in addressing burnout. *Journal of Healthcare Leadership*, *Volume 15*, 169–173. https://doi.org/10.2147/JHL.S389271

Forné, C., & Yuguero, O. (2022). Factor structure of the Maslach Burnout Inventory Human Services Survey in Spanish urgency healthcare personnel: A cross-sectional study. *BMC Medical Education*, *22*(1), 615. https://doi.org/10.1186/s12909-022-03666-3

Garcia, C. L., Abreu, L. C., Ramos, J. L. S., Castro, C. F. D., Smiderle, F. R. N., Santos, J. A. D., & Bezerra, I. M. P. (2019). Influence of burnout on patient safety: Systematic review and meta-analysis. *Medicina (Kaunas, Lithuania), 55*(9), 553. https://doi.org/10.3390/medicina55090553

Gómez-Urquiza, J. L., De la Fuente-Solana, E. I., Albendín-García, L., Vargas-Pecino, C., Ortega-Campos, E. M., & Cañadas-De la Fuente, G. A. (2017). Prevalence of burnout syndrome in emergency nurses: A meta-analysis. *Critical Care Nurse*, *37*(5), e1–e9. https://doi-org.liboff.ohsu.edu/10.4037/ccn2017508

Ham, E., Seto, M. C., Rodrigues, N. C., & Hilton, N. Z. (2022). Workplace stressors and PTSD among psychiatric workers: The mediating role of burnout. *International Journal of Mental Health Nursing, 31*(5), 1151–1163. https://doi.org/10.1111/inm.13015

Hogan, D. C., Teodorczuk, P. A., Hunt, D. G., Pun, D. P., Munro, D. J., & Ewais, D. T. (2022). Schwartz rounds – An organizational intervention to overcome burnout in hospitals. *Australasian Psychiatry*, *30*(1), 139–140. https://doi.org/10.1177/10398562211038915

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, *27*(1), 20–32. https://doi.org/10.1111/inm.12416

Kaiser Family Foundation. (2024). *Mental health care health professional shortage areas (HPSAs)*. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-

hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20Need%20M
et%22,%22sort%22:%22desc%22%7D

Kannai, R., Krontal, S., Freud, T., & Biderman, A. (2024). Balint groups: An effective tool for
improving health professionals' perceived well-being. *Israel Journal of Health Policy Research*,
*13*(1), 31. https://doi.org/10.1186/s13584-024-00618-8

Koutsimani, P., Montgomery, A., Masoura, E., & Panagopoulou, E. (2021). Burnout and cognitive
performance. *International Journal of Environmental Research and Public Health, 18*(4), 2145.
https://doi.org/10.3390/ijerph18042145

Langley, G. J. (Ed.). (2009). *The improvement guide: A practical approach to enhancing organizational
performance* (2nd ed). Jossey-Bass.

Leo, C. G., Sabina, S., Tumolo, M. R., Bodini, A., Ponzini, G., Sabato, E., & Mincarone, P. (2021).
Burnout among healthcare workers in the covid 19 era: A review of the existing literature.
*Frontiers in Public Health*, *9*, 750529. https://doi.org/10.3389/fpubh.2021.750529

Li, Y., Scherer, N., Felix, L., & Kuper, H. (2021). Prevalence of depression, anxiety and post-traumatic
stress disorder in health care workers during the COVID-19 pandemic: A systematic review and
meta-analysis. *PLOS One, 16*, 1-19. DOI: 10.1371/journal.pone.0246454

Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y.,
Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace
violence against healthcare workers: A systematic review and meta-analysis. *Occupational and
Environmental Medicine*, *76*(12), 927–937. https://doi.org/10.1136/oemed-2019-105849

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., Ross, S., Shuldham, C., Bennett, L., & Foot, C. (2018). *A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England*. NIHR Journals Library.

Mahoney, D., Brock, C., Diaz, V., Freedy, J., Thiedke, C., Johnson, A., & Mallin, K. (2013). Balint groups: The nuts and bolts of making better doctors. *The International Journal of Psychiatry in Medicine*, *45*(4), 401–411. https://doi.org/10.2190/PM.45.4.j

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99–113. https://doi.org/10.1002/job.4030020205

Maslach, C., Jackson, S. E., & Leiter, M. P. (1997). Maslach Burnout Inventory: Third edition. In C. P. Zalaquett & R. J. Wood (Eds.), *Evaluating stress: A book of resources* (pp. 191–218). Scarecrow Education.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111. https://doi.org/10.1002/wps.20311

Musker, M., & Othman, S. (2024). Effective interventions to reduce burnout in nurses: A meta-analysis. *Complementary Therapies in Clinical Practice*, *54*, 101827.

National Academies of Sciences, Engineering, and Medicine (2019). *Taking action against clinician burnout: A systems approach to professional well-being.* Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional

Norton, C. (2024). *Assessing for racial bias in the use of seclusion and restraint: A quality improvement project* (p. 5.3 MB) [Pdf]. Oregon Health and Science University. https://doi.org/10.6083/BPXHC42884

Ng, L., Schache, K., Young, M., & Sinclair, J. (2023). Value of Schwartz Rounds in promoting the emotional well-being of healthcare workers: A qualitative study. *BMJ Open*, *13*(4), e064144. https://doi.org/10.1136/bmjopen-2022-064144

Oregon Health Authority. (2022). *Mosman ruling frequently asked questions*. Oregon State Hospital. https://www.mentalhealthalliance.org/wp-content/uploads/2023/06/OSH-mink-mosman-FAQ.pdf

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry : The Journal of the Association of European Psychiatrists, 53*, 74–99. https://doi.org/10.1016/j.eurpsy.2018.06.003

Pereira, S. S., Fornés-Vives, J., Unda-Rojas, S. G., Pereira-Junior, G. A., Juruena, M. F., & Cardoso, L. (2021). Confirmatory factorial analysis of the Maslach Burnout Inventory - Human Services Survey in health professionals in emergency services. *Revista Latino-Americana de Enfermagem*, *29*, e3386. https://doi.org/10.1590/1518-8345.3320.3386

Rotstein, S., Hudaib, A. R., Facey, A., & Kulkarni, J. (2019). Psychiatrist burnout: A meta-analysis of Maslach Burnout Inventory means. *Australasian Psychiatry : Bulletin of Royal Australian and New Zealand College of Psychiatrists*, *27*(3), 249–254. https://doi.org/10.1177/1039856219833800

Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & Andrade, S. M. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PloS One, 12*(10), e0185781. https://doi.org/10.1371/journal.pone.0185781

Schmidt, S. L., da Silva Cunha, B., Tolentino, J. C., Schmidt, M. J., Schmidt, G. J., Marinho, A. D., van Duinkerken, E., Gjorup, A. L. T., Landeira-Fernandez, J., Mello, C. R., & de Souza, S. P. (2024). Attention deficits in healthcare workers with non-clinical burnout: An exploratory investigation. *International Journal of Environmental Research and Public Health, 21*(2), 239. https://doi.org/10.3390/ijerph21020239

Seto, M. C., Rodrigues, N. C., Ham, E., Kirsh, B., & Hilton, N. Z. (2020). Post-traumatic stress disorder, depression, anxiety symptoms and help seeking in psychiatric staff: Trouble de stress post-traumatique, dépression, symptômes d'anxiété et recherche d'aide chez le personnel psychiatrique. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 65*(8), 577–583. https://doi.org/10.1177/0706743720916356

Singh, R., Volner, K., & Marlowe, D. (2024). Provider Burnout. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK538330/

Substance Abuse and Mental Health Services Administration. (2022). *Addressing burnout in the behavioral health workforce through organizational strategies.* National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/pep22-06-02-005.pdf

Tang, Y., Wang, Y., Zhou, H., Wang, J., Zhang, R., & Lu, Q. (2023). The relationship between psychiatric nurses' perceived organizational support and job burnout: Mediating role of

psychological capital. *Frontiers in Psychology*, *14*, 1099687.

https://doi.org/10.3389/fpsyg.2023.1099687

Taylor, C., Xyrichis, A., Leamy, M. C., Reynolds, E., & Maben, J. (2018). Can Schwartz Center Rounds

support healthcare staff with emotional challenges at work, and how do they compare with other

interventions aimed at providing similar support? A systematic review and scoping reviews. *BMJ*

*Open*, *8*(10), e024254. https://doi.org/10.1136/bmjopen-2018-024254

United States Census Bureau. (2023). *QuickFacts Portland city, Oregon*.

https://www.census.gov/quickfacts/fact/table/portlandcityoregon/PST045222

United States Department of Health and Human Services. (n.d.). *Quality improvement activities FAQs.*

Office for Human Research Protections, United States Department of Health and Human
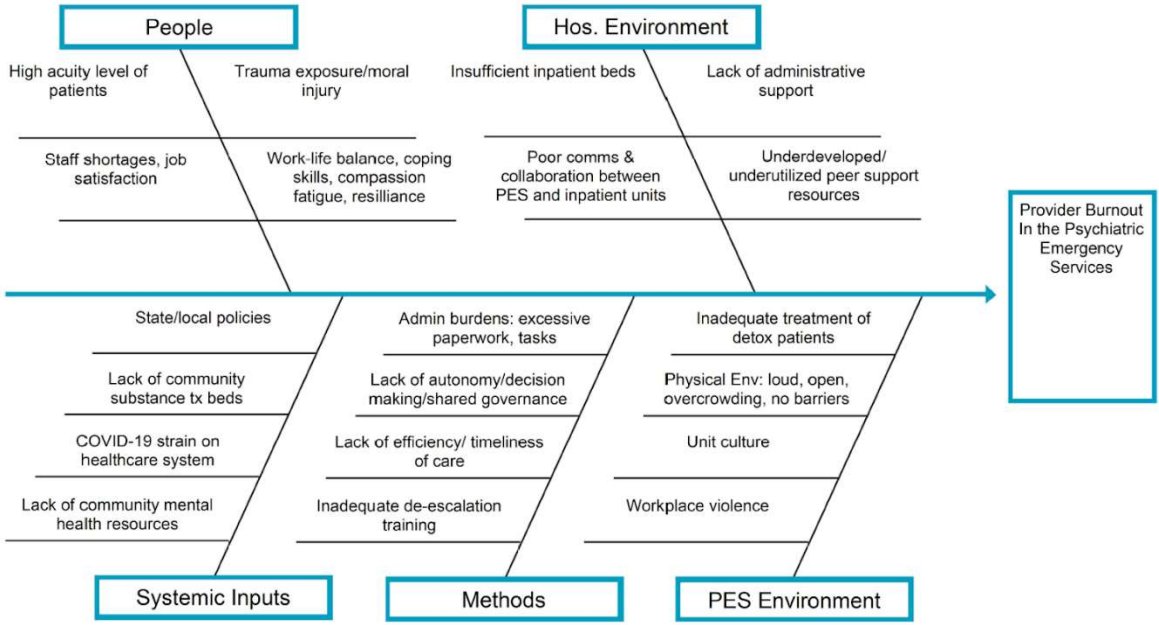
Services. https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/quality-improvement-

activities/index.html

Wampole, D. M., & Bressi, S. K. (2019). Exploring strategies for promoting trauma-informed care and

reducing burnout in acute care psychiatric nursing. *Journal of Nursing Education and Practice*,

*9*(5), 110. https://doi.org/10.5430/jnep.v9n5p110

Whitehead, P. B., Locklear, T. M., & Carter, K. F. (2021). A longitudinal study of the impact of

Schwartz Center Rounds on moral distress. *The Journal of Nursing Administration*, *51*(7-8),
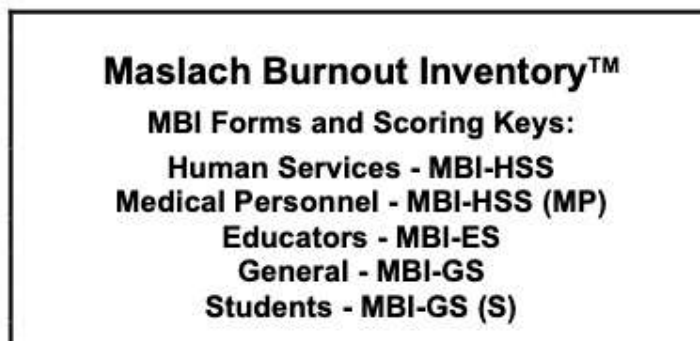
409–415. https://doi.org/10.1097/NNA.0000000000001037

**Appendix A**

**Root Cause Analysis**



| People | | Hos. Environment | |
|---|---|---|---|
| High acuity level of patients | Trauma exposure/moral injury | Insufficient inpatient beds | Lack of administrative support |
| Staff shortages, job satisfaction | Work-life balance, coping skills, compassion fatigue, resilliance | Poor comms & collaboration between PES and inpatient units | Underdeveloped/ underutilized peer support resources |

Provider Burnout In the Psychiatric Emergency Services

| Systemic Inputs | Methods | PES Environment |
|---|---|---|
| State/local policies | Admin burdens: excessive paperwork, tasks | Inadequate treatment of detox patients |
| Lack of community substance tx beds | Lack of autonomy/decision making/shared governance | Physical Env: loud, open, overcrowding, no barriers |
| COVID-19 strain on healthcare system | Lack of efficiency/ timeliness of care | Unit culture |
| Lack of community mental health resources | Inadequate de-escalation training | Workplace violence |

**Appendix B**

**License to Administer Maslach Burnout Inventory - Human Services Survey for Medical**

**Professionals (MBI-HSS MP)**

# Maslach Burnout Inventory™

## MBI Forms and Scoring Keys:

Human Services - MBI-HSS
Medical Personnel - MBI-HSS (MP)
Educators - MBI-ES
General - MBI-GS
Students - MBI-GS (S)

## License to Administer

By Christina Maslach, Susan E. Jackson, Michael P. Leiter,
Wilmar B. Schaufeli & Richard L. Schwab

Published by Mind Garden, Inc.
www.mindgarden.com

## Important Note to Licensee

It is your legal responsibility to compensate the copyright holder of this work — via payment to Mind Garden — for reproduction or administration in any physical or digital medium, including online survey, handheld survey devices, etc.

You agree to track the number of reproductions or administrations, and to compensate Mind Garden for any usage in excess of the quantity purchased.

This license is valid for three years from the date of purchase.

This instrument, and any use thereof, is covered by U.S. and international copyright laws. For any further use or reproduction of the instrument, in whole or in part, contact Mind Garden, Inc.

## Permission Letter

# m\nd garden

**www.mindgarden.com**

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

**Maslach Burnout Inventory forms: Human Services Survey, Human Services Survey for Medical Personnel, Educators Survey, General Survey, or General Survey for Students.**

The license holder has permission to administer the complete instrument in their research, however, only three sample items from this instrument as specified below may be included in the research write-up, thesis, or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument form may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

**Citation of the instrument must include the applicable copyright statement listed below. Sample Items:**

**MBI - Human Services Survey - MBI-HSS:**
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some recipients.

Copyright ©1981 Christina Maslach & Susan E. Jackson.  All rights reserved in all media.
Published by Mind Garden, Inc., www.mindgarden.com

**MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):**
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

Copyright ©1981, 2016 by Christina Maslach & Susan E. Jackson. All rights reserved in all media.
Published by Mind Garden, Inc., www.mindgarden.com

**MBI - Educators Survey - MBI-ES:**
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some students.

Copyright ©1986 Christina Maslach, Susan E. Jackson & Richard L. Schwab.  All rights reserved in all media.  Published by Mind Garden, Inc., www.mindgarden.com

**MBI - General Survey - MBI-GS:**

I feel emotionally drained from my work.
In my opinion, I am good at my job.
I doubt the significance of my work.

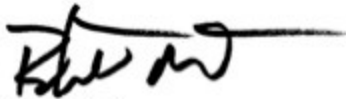**MBI - General Survey for Students - MBI-GS (S):**

I feel emotionally drained by my studies.
In my opinion, I am a good student.
I doubt the significance of my studies.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com

## For Dissertation and Thesis Appendices

This license permits you to administer the complete instrument in your research, however, only the three pre-authorized sample items from this instrument as provided by Mind Garden may be included in the research write-up, thesis, dissertation, or appendices, and only when accompanied by the instrument copyright statement. Detailed information on these requirements is provided in the enclosed permission letter.

## For Results Reporting and Publications

This research license is for data collection, and it permits you to collect and disclose item scores, scale scores, and scores statistics (group average, group standard deviation, T-scores, etc.). You may not include the complete instrument in results reporting or publications – you may include only the three pre-authorized sample items and with copyright language and attribution: see the enclosed permission letter.

This license is for research only and not for providing individual feedback to survey participants. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Note: the list above illustrates some permitted and prohibited uses of the instrument and is not meant to be comprehensive.

## Translations

Translations are available free of charge with license purchase. Contact info@mindgarden.com to request translations. If you would like to make a translation, please complete the Translation Application, available at https://www.mindgarden.com/mind-garden-forms/61-translation-application.html

## All Other Reproductions

For any other reproductions or permissions, please contact info@mindgarden.com

# Appendix C

# Cognitive Burden Survey

**Cognitive Burden Survey**

1. Please rate the perceived cognitive burden this event placed on you by circling the appropriate number:

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| (No burden) | (Mild burden) | (Moderate burden) | (Severe burden) |
| "I appreciated this experience and feel it's worth my time." | "Meh, I don't mind." | "It could use some improvements." | "Please don't make me do this again, definitely not worth my time." |

2. Please share any other thoughts you have about how this can be improved (Optional):

_____

_____

_____

_____

_____

_____

_____

_____

**Appendix D**

**MBI HSS (MP) Subscale Scoring Keys**

## MBI – Human Services, Medical Personnel, and Educators Scoring Key
## Emotional Exhaustion (EE) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on EE items # 1, 2, 3, 6, 8, 13, 14, 16, and 20 that correspond to the unshaded areas on this scoring key. Enter this EE total score on the survey form. Divide the EE total score by the number of answered EE items for an EE average score. Research usually reports the average score.

| How Often 0-6 |
|---|
| 1. _____ |
| 2. _____ |
| 3. _____ |
| 4. _____ |
| 5. _____ |
| 6. _____ |
| 7. _____ |
| 8. _____ |
| 9. _____ |
| 10. _____ |
| 11. _____ |
| 12. _____ |
| 13. _____ |
| 14. _____ |
| 15. _____ |
| 16. _____ |
| 17. _____ |
| 18. _____ |
| 19. _____ |
| 20. _____ |
| 21. _____ |
| 22. _____ |

## MBI – Human Services, Medical Personnel, and Educators Scoring Key
## Depersonalization (DP) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on DP items # 5, 10, 11, 15, and 22 that correspond to the unshaded areas on this scoring key. Enter this DP total score on the survey form. Divide the DP total score by the number of answered DP items for a DP average score. Research usually reports the average score.

| How Often 0-6 |
|---|
| 1. _____ |
| 2. _____ |
| 3. _____ |
| 4. _____ |
| 5. _____ |
| 6. _____ |
| 7. _____ |
| 8. _____ |
| 9. _____ |
| 10. _____ |
| 11. _____ |
| 12. _____ |
| 13. _____ |
| 14. _____ |
| 15. _____ |
| 16. _____ |
| 17. _____ |
| 18. _____ |
| 19. _____ |
| 20. _____ |
| 21. _____ |
| 22. _____ |

## MBI – Human Services, Medical Personnel, and Educators Scoring Key
## Personal Accomplishment (PA) Subscale

**Directions:** Line up this scoring key with the MBI survey form. Sum the survey responses on PA items # 4, 7, 9, 12, 17, 18, 19, and 21 that correspond to the unshaded areas on this scoring key. Enter this PA total score on the survey form. Divide the PA total score by the number of answered PA items for a PA average score. Research usually reports the average score.

| How Often 0-6 |
|---|
| 1. _____ |
| 2. _____ |
| 3. _____ |
| 4. _____ |
| 5. _____ |
| 6. _____ |
| 7. _____ |
| 8. _____ |
| 9. _____ |
| 10. _____ |
| 11. _____ |
| 12. _____ |
| 13. _____ |
| 14. _____ |
| 15. _____ |
| 16. _____ |
| 17. _____ |
| 18. _____ |
| 19. _____ |
| 20. _____ |
| 21. _____ |
| 22. _____ |

**Appendix E**

**Normative Data for MBI HSS (MP)**

## Table 7. Means and Standard Deviations for the MBI-HSS Scales

| | MBI-HSS Scales | | |
| --- | --- | --- | --- |
| | Emotional Exhaustion | Depersonalization | Personal Accomplishment |
| Occupational Subgroups[1] | | | |
| *Social Services (n=1,538)* | | | |
| M | 21.35 | 7.46 | 32.75 |
| SD | 10.51 | 5.11 | 7.71 |
| *Medicine (n=1,104)* | | | |
| M | 22.19 | 7.12 | 36.53 |
| SD | 9.53 | 5.22 | 7.34 |
| *Mental Health (n=730)* | | | |
| M | 16.89 | 5.72 | 30.87 |
| SD | 8.90 | 4.62 | 6.37 |
| *Other (n=2,897)* | | | |
| M | 21.42 | 8.11 | 36.43 |
| SD | 11.5 | 6.15 | 7.00 |

*Note:* Scale scores were calculated using Method 1 (SUM).

**Appendix F**

**MBI HSS (MP) Scoring and Interpretation Guide**

***Note of Caution:*** For both Method 1 and Method 2, each respondent's three scale scores should be determined and these scale scores should be interpreted separately. It is NOT appropriate to add the three scale scores to create a total burnout score.

***Method 1 (SUM).*** For ease of comparing results to research reports that have been published during the past three decades, it is best to add responses to the MBI-HSS items for each scale and use the SUM as the scale score. This method was most often used in burnout research in the human services professions. This scoring method is as follows:

> *Emotional Exhaustion* (SUM) = Items 1 + 2 + 3 + 6 + 8 + 13 + 14 + 16 + 20
> Note: Higher scores indicate higher degrees of burnout.
>
> *Depersonalization* (SUM) = Items 5 + 10 + 11 + 15 + 22
> *Note: Higher scores indicate higher degrees of burnout.*
>
> *Personal Accomplishment* (SUM) = Items 4 + 7 + 9 + 12 + 17 + 18 + 19 + 21
> *Note: Lower scores indicate higher degrees of burnout.*

***Method 2 (AVE).*** For ease of interpretation by respondents, it is useful to calculate the mean response for the items that make up each scale. For all scales, the mean scores can range from 0 (Never) to 6 (Daily). Using Method 2, simply begin by creating the scale Sum and then divide by the number of items in the scale, as follows:

> *Emotional Exhaustion* (AVE) = [Items 1 + 2 + 3 + 6 + 8 + 13 + 14 + 16 + 20] ÷ 9
> *Note: Higher scores indicate higher degrees of burnout.*
>
> *Depersonalization* (AVE) = [Items 5 + 10 + 11 + 15 + 22] ÷ 5
> *Note: Higher scores indicate higher degrees of burnout.*
>
> *Personal Accomplishment* (AVE) = [Items 4 + 7 + 9 + 12 + 17 + 18 + 19 + 21] ÷ 8
> *Note: Lower scores indicate higher degrees of burnout.*

## Interpreting the MBI-HSS Scale Scores

Scores can be interpreted for individual respondents, or MBI-HSS scores for a group of respondents can be treated as aggregate data. With either approach, scores can be interpreted as absolute values or by comparing scores to those of a larger population to determine the individual's relative degree of burnout.

*Note of Caution.* It is important to understand that there is no definitive score that "proves" a person is "burned out."

*Absolute Values.* With this approach, the meaning of scores is straightforward. Simply use the MEAN scale score and consider where it falls along the 7-point response scale. For example, an Emotional Exhaustion MEAN scale score of 3.5 would be interpreted as indicating the respondent felt emotionally exhausted several times a month on average, but not every week; a score of 5.5 would indicate the respondent felt emotionally exhausted several times a week on average, but not every day. Using this method, judgments about whether the experience of each aspect of burnout is sufficiently frequent to be of concern and worth taking seriously are left to the respondent and/or others who are in a position to take corrective steps.

*Degrees of Burnout Relative to Others.* In some situations, when the responses of a large sample of respondents are available, it might be appropriate to compare an individual's score to the scores of other respondents in the sample. For example, Table 7 summarizes data from several large samples of respondents who completed the MBI-HSS. Using data such as these, a person's relative degree of burnout can be compared to the average for their group. Using the publisher's online scoring service, users can easily obtain reports that include normative data for their particular sample of users. Users who are interested in obtaining reports that include normative data should go to www.mindgarden.com.

As with Method 1, comparing a respondent's score to the scores of others leaves the responsibility for making judgments about whether the experience of each aspect of burnout is sufficiently frequent to be of concern with the respondent and/or other people who are in a position to take corrective steps.

**Appendix G**

**Peer Support Groups Discussion Questions**

**Peer Support Groups Discussion Questions**

The following questions can be used by the group leader to guide the discussion as needed:

1. What are you feeling about the case?
2. What part of this case was most challenging for you emotionally?
3. How did you cope with the feelings that arose from this case?
4. What support did you receive from your colleagues, and what additional support would have been helpful?
5. What do you think is happening in the doctor patient relationship?
6. How has this case affected your perspective on patient care?
7. What challenges did you face in dealing with this case?
8. How are transference and/or countertransference at play in this case?
9. What are different strategies or perspectives that might improve the interaction or outcome?
10. How do you think this case could have been handled differently?
11. What support do you need to handle similar cases in the future?
12. What have we learned from this discussion?

**Appendix H**

**Peer Support Groups Format, Purpose, and Ground Rules**

## Welcome to Provider Peer Support Groups!

### Format

1. **Introduction:** Brief explanation of the purpose and ground rules.
2. **Case Presentation:** In the first 10 minutes, the group facilitator will present a patient case.
3. **Discussion:** Participants share their thoughts, feelings, and experiences related to the presented case. Focus is on the emotional, relational, and ethical aspects of the case.
4. **Reflection and Closing:** The facilitator summarizes the discussion, highlighting key insights.

### Purpose

1. **Emotional Support:** Provide a supportive environment for providers to discuss and process their emotional and relational experiences with patients.
2. **Community:** Help reduce feelings of isolation by sharing and discussing difficult cases in a supportive group setting.
3. **Professional Development**: Foster personal and professional growth by reflecting on challenging cases and learning from the experiences of peers.

### Ground Rules

1. **Focus on Feelings:** The primary focus is on the emotional and relational aspects of the case, rather than clinical details or technicalities.
2. **Non-directive:** The group should avoid giving direct advice or solutions. The focus is on exploring and understanding emotions and relationships, not on solving problems.
3. **Facilitator and Co-facilitator Roles**: The facilitator and co-facilitators guide the discussion and ensure that the ground rules are followed.
4. **Confidentiality:** All discussions within the group are confidential. Participants agree not to share details of the cases or personal experiences discussed outside the group.
5. **Respect:** Participants must respect each other's opinions and experiences, creating a safe and non-judgmental space for sharing.
6. **Listening:** Active listening is essential. Members should listen attentively without interrupting, allowing the speaker to fully express their thoughts and feelings.
7. **Participation:** All members are encouraged to participate, share, and reflect. You are welcome to share your own experiences, comment on those of others, or simply listen.

**Appendix I**

**Letter of Support from Clinical Agency**

<u>Letter of Support from Clinical Agency</u>

Date: *08/07/2024*

Dear Marisa Arana and Teri Bartlow,

This letter confirms that I, Rodney Olin, allow Marisa Arana and Teri Bartlow (OHSU Doctor of Nursing Practice Students) access to complete their DNP Final Project at our clinical site. The project will take place from approximately September 2024 to January 2024.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s): Unity Center for Behavioral Health – Psychiatric Emergency Services**
  **Address**: 1225 NE Second Ave, Portland, OR 97232
- **Project Plan:**
  - Identified Clinical Problem: Burnout in PES Providers
  - Rationale: The IHI Model for Improvement is a developed framework and methodology for improvement efforts in healthcare, will be used to implement a quality improvement project with PES providers. The intervention, Peer Support Groups, is based on a combination of elements from both Balint Groups and Schwartz Rounds. Each group is about 60 minutes where a case is presented by a facilitator and then the group discusses. The emphasis is on the emotional and relational aspects of the case, not the clinical ones.
  - Specific Aims: By the end of November of 2024, participating PES providers' perceptions of personal burnout will improve by 10%. Participating providers' scores on the Maslach Burnout Inventory Human Services Survey for Medical Professionals subscales will improve in response to Peer Support Groups PDSA cycles.
  - Methods/Interventions/Measures: Peer Support Groups is based on a combination of elements from both Balint Groups and Schwartz Rounds. Each group will last 40-60 minutes with time for a case presentation and discussion. The emphasis is on the emotional and relational aspects of the case. Before and after these meetings, participants will fill out an anonymous questionnaire that measures burnout and cognitive burden. Scores will be compared before and after to see if the intervention improved burnout. There would be 3 meetings, 3 weeks apart, planned for October and November of 2024. The Maslach Burnout Inventory Human Services Survey for Medical Personnel will be used.
  - Data Management: Hardcopy surveys will be given before and after intervention without collecting names in order to maintain confidentiality. Data will be transcribed and analyzed in Excel and kept in password protected computers to ensure security.
  - Site Support: Access to Unity PES by badge. Authorize staff to participate in intervention. Allow distribution of surveys and collection of data. Allow time for staff to participate in intervention. Allow space for intervention.

During the project implementation and evaluation, Marisa Arana and Teri Bartlow will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Marisa Arana and Teri Bartlow and Dr. Rodney Olin, DNP (student's DNP Project Chairperson).

Regards,

Dr. Rodney Olin, DNP                                                    roolin@lhs.org    503-875-9705
DNP Project Preceptor

*Rodney Ol, DNP*                                    8/11/2024
Signature                                                    Date Signed

**Appendix J**
**Promotional Poster**

**Appendix K**
**Quotes from participants**

**Quotes from participants**

These quotes were recorded during the final intervention.

In response to feeling frustrated towards clients, one participant said:

*"This is not me; this isn't the person who went into this work."*

When asked how it feels to take care of clients like the one mentioned in the case presentation, a participant said:

*"I often feel hopeless, and wonder, what's the point."*

Another said:

*"I feel guilty and frustrated, seeing so many unmet needs."*

When speaking about clients with history of violence, one participant shared:

*"As a provider working in triage, I'm making a decision to keep someone and put that burden on the nurses and other staff. I often feel guilty when balancing the needs of clients and the safety of my colleagues."*

When asked how participants usually handled the emotions that come up during difficult cases like the one presented, a participant said:

*"I usually just talk to the CIS [social worker] I'm working with that day. We share our frustrations with each other."*

When discussing the case presentation about a patient who presents frequently due to lack of supportive systems outside the hospital, a participant wondered:

*"What's our role? Are we even helping? These are the cases that lead to burnout. It feels like there is nothing we can do to help."*

Future directions for the project:

"A lot of the cases that bring up big emotions are brought to complex case conference. I recommend adding time to bring up emotions and feelings of burnout to this meeting. Staff don't have time to add another meeting to their schedules, so creating a completely separate meeting isn't realistic."

Another said in response, "Yes, leveraging something that already exists would work better."

"Teaching staff how to do a 5-minute emotional check-in after a difficult event. Almost like a code gray."

"Introducing a mindfulness app could be helpful. Something simple that anyone can add to their phones and fit in to their day."

**Appendix L**
**OHSU IRB Approval**



NOT HUMAN RESEARCH

September 3, 2024

Dear Investigator:

On 9/3/2024, the IRB reviewed the following submission:

| | |
|---|---|
| Title of Study: | Addressing provider burnout with peer support groups: A quality improvement project |
| Investigator: | Rodney Olin |
| IRB ID: | STUDY00027644 |
| Funding: | None |

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

**Appendix M**
**Legacy IRB Approval**

**LEGACY RESEARCH INSTITUTE**
LEGACY HEALTH

Legacy Research Institute
1225 N.E. Second Ave.
Portland, OR 97232

503.413.2491 *phone*
503.413.4942 *fax*

## LEGACY HEALTH INSTITUTIONAL REVIEW BOARD

### NOTICE OF IRB ACTION

| | |
|---|---|
| Protocol: *A Quality Improvement Project: Addressing Provider Burnout in a Psychiatric Emergency Services Setting* | |
| Principal Investigator: Marisa Arana/Teri Bartlow | Board Action: QI Determination |
| Submission type/date: QI Project 9/4/24 | Date of Board Action: 9/17/24 |
| Sponsor: none | Study Risk Level: Minimal Risk – QI Non-Human Subjects Determination |
| Site(s): Unity | Jurisdiction: OHRP/OCR |
| IRB Tracking Number: 2203<br><br>Reviewing IRB: Expedited/Exempt | Continuing Review: NA |

### SUBMITTED DOCUMENTS REVIEWED

- ✓ Legacy IRB Form:
    - ○ Statement of mutual agreement - Marisa Arena and Teri Bartlow
- ✓ Investigator's CV:
    - ○ Arana_Marisa_CV_2024
    - ○ CV_Bartlow
- ✓ Study Staff Training Information: CITI:
    - ○ CITI GCP Cert_Bartlow
    - ○ CITI HSR Cert_Bartlow
    - ○ CITI OHSU HSR Cert_Bartlow
    - ○ CITI RCR Cert_Bartlow
    - ○ citiCompletionCertificate_11089979_48264208
    - ○ citiCompletionCertificate_11089979_57029364
    - ○ citiCompletionCertificate_11089979_57029365
    - ○ citiCompletionCertificate_11089979_57029366

### REVIEW

| REVIEW TYPE | IRB ACTION |
|---|---|
| ✓ Exemption Review<br>✓ QI Review | ✓ Approved as submitted<br>✓ Not Human Subject Research Determination |

Legacy Health IRB – NOTICE OF IRB ACTION – Version May 2023

**ADDITIONAL FINDINGS AND REQUIREMENTS FOR THIS STUDY**

✓ The Board determined that the activity described consists of quality improvement only and does not meet the definition for human subjects research.

**IRB ACTION SIGNATURE**

APPROVED BY LEGACY IRB – EXPEDITED REVIEW – DATE: <u>9/27/24</u>

R Young

Rebecca Young – Research Regulatory Specialist

_____     _____**9/17/24**_____
**Rebecca Young, MA, CCRP**                                        **DATE**
**Legacy IRB Research Regulatory Specialist**

**IRB CONTACT**

If you have questions or concerns or wish to ask the IRB to reconsider its action, please contact Rebecca Young, Research Regulatory Specialist at, reyoung@lhs.org.

**IRB INFORMATION**

Legacy IRB:  FWA00001280
REG: #1 (Good Sam): 00000677
REG: #2 (Emanuel): 00000678
LRI IRB (LRI): 00011999

**END OF IRB ACTION DOCUMENT**

**Appendix N**
**Project Timeline**

| Timeline (2024-2025) | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | April | May | June | July | August | September | October | November | December | January | February | March |
| Initial Research (703A) | X | X | | | | | | | | | | |
| Correspondence hospital Peer Support Program (703A) | | X | X | | | | | | | | | |
| Discussions with hospital leadership about Schwartz Rounds (703A) | | | X | | | | | | | | | |
| Intervention development based on Scwartz Rounds and Balint Groups (703B) | | | | X | | | | | | | | |
| Final presentation meeting with hospital Medical Director and Chief Nursing Officer (703B) | | | | | X | | | | | | | |
| Submission to OHSU & Hospital IRB (703B) | | | | | X | | | | | | | |
| OHSU & Hospital IRB Approval Received (703B) | | | | | | X | | | | | | |
| PDSA Cycle 1: Peer Support Group Intervention 1 (703B) <br> - In person meeting on Oct 24th with refreshments provided <br> - Email invites sent on Oct 17th <br> - Text message invite sent Oct 15th | | | | | | | X | | | | | |
| PDSA Cycle 2: Peer Support Group Intervention 2 (703B) <br> - Meeting moved online via Teams on Nov 14th with gift card raffle incentive added <br> - Email invites sent on Oct 17th & Nov 11th <br> - Text message invite sent Nov 7th | | | | | | | | X | | | | |
| PDSA Cycle 3: Peer Support Group Intervention 3 (703B) <br> - Meeting conducted via Teams on Dec 5th with gift card raffle incentive continued <br> - Email invites sent on Oct 17th and Nov 24th <br> - Text message invite sent Nov 29th and reminder text send on Dec4th <br> - Promotional materials posted in common spaces on Nov 29th. | | | | | | | | | X | | | |
| Complete sections 13-17 of final paper | | | | | | | | | | X | | |
| Prepare for project dissemination | | | | | | | | | | | X | |
| Present Final Project | | | | | | | | | | | | X |