How Can Health Care Organizations Address Burnout? A Description of the Dr. Lorna Breen Act Grantees

Candice Chen, MD, MPH, Julia Strasser, DrPH, MPH, Randl Dent, PhD, MS, Janice Blanchard, MD, PhD, MPH, Maria Portela-Martinez, MD, MPH, Lauren Muñoz, RN, PhD, Becka DeSmidt, MPH, and Jessica Perlo, MPH

ABOUT THE AUTHORS

Candice Chen, Julia Strasser, Randl Dent, and Lauren Muñoz are with the Fitzhugh Mullan Institute for Health Workforce Equity, Milken Institute School of Public Health, George Washington University, Washington, DC. Janice Blanchard and Maria Portela-Martinez are with the School of Medicine and Health Sciences, George Washington University. Becka DeSmidt and Jessica Perlo are with the Institute for Healthcare Improvement, Boston, MA.

AJPH Supplement 2, 2024, Vol. 114, No. S2

Burnout among health care workers has been rising for years and is associated with increased risk of job dissatisfaction, suicide, and poor patient outcomes.[1–5] COVID-19 brought this issue to the forefront. By the end of 2021, more than 60% of physicians and advanced practice clinicians reported burnout, and in 2022, 45% of nurses reported feeling burned out, 51% emotionally drained, and 56% used up.[6,7] In 2021, more than half of public health workers reported symptoms of posttraumatic stress disorder, and nearly a third reported an intention to leave their organization in the next year.[8]

THE HEALTH CARE PROVIDER PROTECTION ACT

Over the course of the pandemic, the health workforce experienced new layers of pressure, including uncertainty and fear about the virus, lack of personal protective equipment, retribution for health workers speaking out, misinformation, and staffing shortages.[9] Lorna Breen was an emergency medicine physician in New York City's Allen Hospital. In early 2020, when the city was inundated by severely ill COVID-19 patients, Breen worked to treat an onslaught of COVID-19 patients and eventually contracted the virus herself. The tremendous stress and tragedy she experienced took a devastating toll: on April 26, 2020, Breen died by suicide. Her family later learned that she had avoided seeking help out of fear that it would cause her to lose her medical license or the respect of colleagues.

Her story quickly garnered national attention. The *New York Times* published a story about it the day following her death, increasing awareness among key policymakers about health care provider burnout. In March 2022, President Biden signed the Dr. Lorna Breen Health Care Provider Protection Act (Pub L No. 117-105), establishing grants to health care entities and training programs to promote mental health and resiliency for health care professionals and trainees.[10]

As part of this work, the Health Resources and Services Administration (HRSA) received American Rescue Plan funding, awarding three sets of grants that began in January 2022: (1) Promoting Resilience and Mental Health Among the Health Professional Workforce (10 grantees up to $3 million), (2) Health and Public Safety Workforce Resiliency Training Program (34 grantees up to $2.3 million), and (3) a technical assistance center to support grantees' work and contribute to a national framework to address burnout, suicide, mental health, and resiliency ($6 million). All grants were for three years.

We provide an early, exploratory look at the strategies of the 44 HRSA grantees as a first step to understanding what works and how. We reviewed 43 of the 44 grant proposals, thematically examining grantees' approaches based on areas identified in Leiter and Maslach's six organizational factors that drive burnout, the US Surgeon General's 2022 Advisory on Building a Thriving Health Workforce, and the National Academy of Medicine's 2019 Consensus Study on Taking Action Against Clinician Burnout.[11–13] We also conducted interviews with 30 grantees, which provided an opportunity to fill in gaps from the proposals.

ORGANIZATION CHARACTERISTICS

The 44 grantees comprised academic institutions, hospitals, health systems, community health centers, nonprofit organizations, national membership associations, and others (Table A, available as

a supplement to the online version of this article at http://www.ajph.org). Many grantees worked across multiple target populations, including frontline clinicians, wraparound or support service professionals (e.g., social workers, peer support workers, community health workers), public health workers, and public safety workers, including emergency response and police officers. The majority of the grantees (40) also worked with students or trainees across clinician and support service professions.

MENTAL HEALTH AND BURNOUT STRATEGIES

We classified grantee activities into broad categories based on their intended level of effect: (1) workplace and learning environment, (2) organization, (3) health care system, and (4) society and culture (Box 1).

Workplace and Learning Environment

At the workplace and learning environment level, 24 grantees were addressing mental health and substance use screening and services, 28 were targeting stress and trauma services, and 39 were offering resilience training and supports to improve the experience of their workers. Strategies to address worker mental health included expanding screening and mental health services through in-person and virtual offerings with consideration for maintaining worker privacy to encourage uptake. Stress and trauma services included training (e.g., psychological, stress, and mental health first aid; critical incident stress management) and establishing stress and trauma supports (e.g., peer-to-peer support systems, Schwartz rounds, crisis response teams). Resilience activities included mindfulness and well-being training as well as physical fitness tools, tobacco cessation support, and healing spaces, such as onsite gardens.

Organization

At the organization level, grantees were addressing meaning and purpose in work, teamwork and camaraderie, workload, workflow, administrative burdens, practice supports, and career development and supports for workers. In many cases, grantees were first focused on the organizational change strategies needed to engage health workers and leaders in addressing mental health and burnout. Strategies included strengthening organizational well-being infrastructure (24 organizations) through creating well-being offices, committees, champions, and strategic plans; reviewing policies and procedures for well-being implications

BOX 1— Organizational Strategies to Address Health Worker Mental Health and Burnout

Society and culture: health care system	Advocacy • advocacy training	Social justice • social justice training		
Organization: management	Organizational infrastructure • well-being champions, staffing, committees, offices, plans • leadership training • policy and program review	Worker engagement • worker feedback, focus groups, town halls • participative management, shared governance	Measurement • annual employee surveys • pulse surveys • using measures to inform interventions	Unit-level methods • well-being quality improvement • supervisor/manager training (e.g., wellness, trauma-informed supervision, coaching)
Organization: worker and learner experience	Meaning and purpose • communicating organizational values Teamwork/camaraderie • training for team-based care and team communication	Work–life integration • leave policies (e.g., sick, family) • enhanced employee assistance programs • addressing workers' social determinants Career development • mentorship, resources • career ladders	Work environment and policies • workload (e.g., staffing, teams, scheduling) • workflow and administrative burden • payment and incentive structures	Practice supports • training for nonescalation and patient communication Diversity, equity, inclusion • training and inclusive programs • addressing discrimination/bias
Workplace and learning environment: individual supports	Mental health • screening and services (e.g., virtual, in-person, community-level) • culture change (e.g., messaging to reduce stigma)	Stress/trauma • peer training (e.g., psychological, stress, mental health first aid) • crisis supports (i.e., critical incident response, Schwartz rounds)	Resilience/well-being • training and resources • physical (e.g., fitness, rooms, gardens, tobacco cessation) • culture change (e.g., supporting leave)	

(10 organizations); seeking worker feedback (24 organizations) through town halls, listening sessions, and focus groups; and leadership training (15 organizations). Ten organizations were using quality improvement strategies to partner with worker teams to develop, implement, and test meaningful solutions that used existing infrastructure in organizations and linked worker well-being to established quality and patient safety efforts.

Additionally, all grantees were measuring the impact of their interventions. Measures included educational outcomes of trainings (e.g., reaction and change in knowledge, skills, and behaviors), use of well-being resources (e.g., employee assistance programs, paid time off) and mental health services, work and learning environment changes (e.g., workload, team and supervisor support, discrimination, curriculum), and worker and trainee outcomes (e.g., mental and physical health, resilience, burnout, moral distress). Some grantees also planned to assess organization-level outcomes (e.g., attrition and retention, absenteeism, work productivity, cost savings). The most common measurement instruments are summarized in Table B (available as a supplement to the online version of this article at http://www.ajph.org).

Many grantees also recognized that health workers experience additional stressors related to their race/ethnicity, gender, socioeconomic status, and other characteristics and highlighted the need to collect and stratify measures based on key demographics. Five organizations explicitly had diversity, equity, and inclusion as a core aspect of addressing burnout, including leadership training on inclusion and equity, measuring the experience of discrimination, and developing data systems to improve measurement and tracking burnout and attrition for different groups. Five programs were addressing workers' social determinants of health (e.g., low-income levels, food insecurity), and three were developing career ladders and professional supports for worker growth and retention.

Health Care System and Society and Culture

A small number of grantees were broadening their approach to include activities focused on health care system– and society-level changes. One grantee included advocacy training to address systemic causes of burnout, and another included social justice training. Eleven grantees contained organizational diversity, equity, and inclusion activities in their work, including training on creating inclusive spaces and antiracist teaching practices.

CHALLENGES TO IMPLEMENTATION

Grantees reported that the ongoing COVID-19 pandemic created a difficult landscape to engage health workers in additional activities, even when those activities were focused on reducing burnout. These engagement challenges were reported with workers, trainees, organizational leaders, and external partners.

LOOKING AHEAD

This, to our knowledge, first look at the 44 HRSA-funded organizations working to decrease burnout among health workers and trainees has identified the range of approaches necessary to address this complex problem. The most effective approaches will take into account both the intervention strategy (the "what") and the method for change (the "how"). There is no single solution, and worker engagement through participative management or more formal worker engagement strategies, such as shared governance, will likely be critical for success.[14]

The grantees' work also highlights the central role of diversity, equity, and inclusion in improving mental health and addressing burnout among workers and trainees. Improving the average well-being of a population without giving attention to segments in the population can exacerbate disparities. Thus, evaluation data must be analyzed by subgroup, and efforts should be adapted to ensure that those with the most need are both benefiting from interventions and receiving additional support as necessary. As interventions for health worker well-being become more widespread over the coming years, diversity, equity, and inclusion will need consideration in all elements of individual and organizational interventions.

Although most grantees were focused on organizational as well as workplace- and learning environment–level changes, including advocacy and social justice training suggests the need to focus externally to fully address worker mental health and burnout. Policies, programs, and the societal drivers of health worker burnout need to be the focus of ongoing efforts in this area. The work of changing organizations, health care systems, and society is considerable. However, the need for change is great. During an interview, one program director shared that it was the suicide of a former colleague that led her to engage in well-being work. When asked what she hopes to accomplish with this grant, she shared, "Nobody else should die because of this." AJPH

CORRESPONDENCE

Correspondence should be sent to Candice Chen, MD, MPH, Fitzhugh Mullan Institute for Health Workforce Equity, Milken Institute School of Public Health, The George Washington University, 2175 K St NW, Suite 250, Washington, DC 20037 (e-mail: cpchen@gwu.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

PUBLICATION INFORMATION

Full Citation: Chen C, Strasser J, Dent R, et al. How can health care organizations address burnout? A description of the Dr. Lorna Breen Act grantees. *Am J Public Health*. 2024;114(S2):S148–S151.

Acceptance Date: September 15, 2023.

DOI: https://doi.org/10.2105/AJPH.2023.307459

CONTRIBUTORS

C. Chen, J. Strasser, and R. Dent contributed to the design of the proposal analysis. C. Chen, J. Strasser, R. Dent, J. Blanchard, and M. Portela-Martinez contributed to the proposal analysis. C. Chen, J. Strasser, R. Dent, L. Muñoz, B. DeSmidt, and J. Perlo contributed to the interviews. C. Chen, J. Strasser, and L. Muñoz drafted the editorial. R. Dent, J. Blanchard, M. Portela-Martinez, B. DeSmidt, and J. Perlo contributed significant edits to the editorial.

ACKNOWLEDGMENTS

All authors received grant funding from the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $5 940 548 with zero percentage financed with nongovernmental sources.

The authors would like to acknowledge Emma Dewhurst for her contributions to the interview process.

Note. The contents of this editorial are those of the authors and do not necessarily represent the official views of, nor an endorsement by, the HRSA, the HHS, or the US government.

CONFLICTS OF INTEREST

The authors have no conflicts of interests to report.

REFERENCES

1. Davis MA, Cher BA, Friese CR, et al. Association of US nurse and physician occupation with risk of suicide. *JAMA Psychiatry.* 2021;78(6):651–658. https://doi.org/10.1001/jamapsychiatry.2021.0154
2. Al-Ghunaim TA, Johnson J, Biyani CS, Alshahrani KM, Dunning A, O'Connor DB. Surgeon burnout, impact on patient safety and professionalism: a systematic review and meta-analysis. *Am J Surg.* 2022;224(1, 1 pt A):228–238. https://doi.org/10.1016/j.amjsurg.2021.12.027
3. Clark RRS, Lake E. Burnout, job dissatisfaction and missed care among maternity nurses. *J Nurs Manag.* 2020;28(8):2001–2006. https://doi.org/10.1111/jonm.13037
4. de Oliveira GS, Chang R, Fitzgerald PC, et al. The prevalence of burnout and depression and their association with adherence to safety and practice standards: a survey of United States anesthesiology trainees. *Anesth Analg.* 2013;117(1):182–193. https://doi.org/10.1213/ANE.0b013e3182917da9
5. Cimiotti JP, Aiken LH, Sloane DM, Wu ES. Nurse staffing, burnout, and health care–associated infection. *Am J Infect Control.* 2012;40(6):486–490. https://doi.org/10.1016/j.ajic.2012.02.029
6. Linzer M, Jin JO, Shah P, et al. Trends in clinician burnout with associated mitigating and aggravating factors during the COVID-19 pandemic. *JAMA Health Forum.* 2022;3(11):e224163. https://doi.org/10.1001/jamahealthforum.2022.4163
7. Martin B, Kaminski-Ozturk N, O'Hara C, Smiley R. Examining the impact of the COVID-19 pandemic on burnout and stress among US nurses. *J Nurs Regul.* 2023;14(1):4–12. https://doi.org/10.1016/S2155-8256(23)00063-7
8. de Beaumont Foundation. The impact of the COVID-19 pandemic: rising stress and burnout in public health. March 2022. Available at: https://debeaumont.org/wp-content/uploads/dlm_uploads/2022/03/Stress-and-Burnout-Brief_final.pdf. Accessed September 25, 2023.
9. Xue Y, Lopes J, Ritchie K, et al. Potential circumstances associated with moral injury and moral distress in healthcare workers and public safety personnel across the globe during COVID-19: a scoping review. *Front Psychiatry.* 2022;13:863232. https://doi.org/10.3389/fpsyt.2022.863232
10. Dr. Lorna Breen Health Care Provider Protection Act. Pub L No. 117-105, HR 1667, 117th Cong, 2nd Sess. (2022).
11. Leiter MP, Maslach C. Six areas of worklife: a model of the organizational context of burnout. *J Health Hum Serv Adm.* 1999;21(4):472–489. https://www.jstor.org/stable/25780925
12. Murthy VH. Addressing health worker burnout: the US Surgeon General's Advisory on Building a Thriving Health Workforce. 2022. Available at: https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf. Accessed September 25, 2023.
13. National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.* Washington, DC: National Academies Press; 2019. https://doi.org/10.17226/25521
14. Kyystönen M, Tomietto M, Huhtakangas M. Research on hospital-based shared governance: a scoping review. *Int J Health Gov.* 2020;25(4):371–386. https://doi.org/10.1108/IJHG-04-2020-0032