Stress and Provider Retention in Underserved Communities

A. Seiji Hayashi, MD, MPH
Emily Selia, MPH
Karen McDonnell, PhD

Key Words: Workplace stress, provider retention, community health centers.

Clinicians and staff in health care organizations experience stress and burnout due to both job conditions and unique pressures of the medical field. Stress and burnout have consequences not only for the health and wellness of employees but for patients through poor quality care. Health care organizations and systems are affected when it causes decreased productivity and even attrition. In safety net health centers, the loss of clinicians and staff and decreased productivity further strain an already resource-poor system, creating a vicious cycle as more demands are placed on those who remain. Acutely aware of this phenomenon, the Association of Clinicians for the Underserved (ACU) sought to better understand stress and burnout experienced by its members in hopes of developing strategies and interventions to break this cycle. This column describes the initial findings from a survey conducted to assess stress and burnout among ACU members.

Background

Health care professionals commonly experience stress at their work site; contributory factors include heavy workload, understaffing, high intensity of work, job insecurity,[1] and risk of injury or harm.[2] Poor communication skills, especially among superiors, and unpleasant physical environments can also contribute to stress.[3] Stress commonly arises in a variety of professions, including social work, occupational therapy, nursing, and medicine.[4] Research on nurses has found sleep deprivation, ambiguity in work roles, and time pressures to be linked to stress, while studies of physicians found links

DR. HAYASHI *is an Assistant Research Professor in the Department of Health Policy at the George Washington University (GWU) School of Public Health and Health Services, where he can be reached at 2121 K Street NW, Suite 200, Washington, DC 20037; (202) 994-4128; sphash@gwumc.edu.* ***MS. SELIA*** *is an Environmental Health Scientist at the U.S. Environmental Protection Agency, Washington, DC. The views expressed in this paper are those of the author and do not necessarily represent those of the U.S. EPA. No official Agency endorsement should be inferred.* ***DR. MCDONNELL*** *is an Associate Professor in the Department of Prevention and Community Health at the GWU School of Public Health and Health Services.*

to unmet patient expectations, threats of litigation, interpersonal conflicts, and coping with the death of patients.[2]

Safety net health centers, like other health care delivery settings, can cause stress for their clinicians and staff. Due to limited organizational and systems resources, safety net providers face additional challenges such as severely inadequate patient care space and lack of essential supplies. Outside their own facilities, safety net providers lack systems resources such as specialists willing to see uninsured or underinsured patients. The recent economic downturn has caused a rise in uninsured patients seen by safety net clinics and further stretches their resources.[5] Low literacy, poverty, and other socioeconomic challenges faced by patients also increase the workload for providers in such settings.

Despite the general lack of resources, safety net health centers and their staffs possess characteristics that make them resilient to some of the stressors. For example, safety net providers share a common mission to serve medically vulnerable communities and come into the setting with a systems perspective and are well-aware of potential challenges. Safety net health centers also self-select individuals with personal characteristics and skills suited to working with poor and underserved populations. For example, many have taken initiative to develop cultural competency skills as well as language skills specific to community needs.

Nevertheless, stress may lead to a wide range of effects for both workers and organizations. Negative health outcomes of stress include anxiety, depression, immune deficiencies, and cardiovascular problems.[6] Stress has also been associated with occupational burnout, characterized by increased feelings of exhaustion, cynicism and inefficacy.[7] Stress may directly and indirectly affect critical organizational measures such as job performance, absenteeism, errors in treatment, patient satisfaction, and turnover.[4] Factors such as absenteeism and intentions of workers to quit all have an impact on the overall success of an organization, as the cost of recruiting and training adds additional financial burdens.

The negative consequences of stress and burnout place delicate health care systems for the poor and underserved at particular risk. In an effort to take the initial steps in developing a program to combat the problem, this study aimed to assess the degree of stress and burnout experienced by those who work in safety net settings as well as the characteristics of their practice environment.

Methods

ACU conducted an anonymous online survey of current members. Questions focused on perceptions, degree, and impact of stress, burnout, and workplace wellness. The survey also collected information about characteristics of staff, organizations, and any existing workplace wellness programs. Staff members of ACU constructed the survey in cooperation with a public health student and faculty members at a school of public health.

Recruitment consisted of e-mail messages to current ACU members, announcement on the ACU website, and announcement in the member newsletter. The survey was

open for approximately six weeks, and solicitation e-mail messages were sent to a total of 808 individuals though, due to initial errors in the database, some individuals did not receive all of the four reminders. Roughly 24% of the e-mail messages were returned as undeliverable, leaving the maximum number of individual addresses receiving the solicitation at 617. Solicitations also encouraged recipients to forward the survey to others in the field. Furthermore, the survey was open to the public and readily available to anyone who visited the ACU website. In total, 113 surveys were completed.

Results

Characteristics of the 113 respondents are listed in Table 1. Ninety-four of the 113 individuals who completed the survey have current ACU membership, representing 12% of our target population.

Experience of stress. Figure 1 describes the response to the statement, “My job is a significant source of stress in my life.” Overall, 61.7% of respondents agreed or somewhat agreed with this statement, 10.3% neither disagreed nor agreed, 28.0% disagreed or somewhat disagreed. Comparing the responses by gender, full-time/part-time status, and health center location, we find that both females and males responded similarly, but full-time staff (70.6%) and those working in rural locations (71.4%) had higher degrees of agreement that their jobs were a significant source of stress.

Sources of stress. Table 2 shows how respondents scored different sources of stress. We used a 5 point scale with 1 being least stressful and 5 being most stressful. Respondents rated *Insufficient resources for my patients*, *Workload*, and *Insufficient resources at my organization* as being the three greatest sources of stress. *Relationships with coworkers*, *Benefits*, and *Job security* were the least endorsed causes of stress.

Staff retention. When asked, “How likely are you to remain at your current organization in three years?” 60.2% responded *very likely* or *extremely likely* and only 10.6% responded *not at all likely*. To the question, “How likely are you to remain in the field of work in three years?” 82.3% responded *very likely* or *extremely likely*, and 1.8% responded *not at all likely*. In Table 3, responses were converted to a numerical scale (*not at all likely* = 1, *somewhat likely* = 2, *very likely* = 3, *extremely likely* = 4). To the question, “How likely are you to remain at your current organization in three years?” male respondents had a mean score of 3.11 and females a mean score of 2.70. To the same question, full-time and part-time workers had a mean score of 2.60 and 3.10, respectively. Respondents working in urban or suburban locations had a mean score of 2.89 and those in rural areas had a mean score of 2.33. Length of time in underserved care (five years or less vs. longer than five years) showed similar mean scores (2.76 and 2.86, respectively). Men scored an average of 3.74 and women scored 3.26 in response to the question, “How likely are you to remain in the field of work in three years?”

Stress and staff retention. Responses to “My job is a significant source of stress” and “How likely are you to remain at your current organization in three years?” seem to show that the more a job is a significant sources of stress, the less likely the individual will remain at their current organization in three years.

Table 1.

RESPONDENT CHARACTERISTICS (N=113)

Characteristics	Percent of respondents
Gender	
Female	58.4
Male	33.6
(No response)	8.0
Job type	
Physicians	42.5
Nurses	25.7
Administrators	31
Working status	
Full-time	48.7
Part-time	44.2
Location of work	
Urban	70.8
Suburban	18
Rural	13
Practice setting	
FQHC	52.2
Hospitals	12.4
School-based clinics	11.5
Mobile clinics	10
Free clinics	10
University clinics	9
Insurance accepted at practice	
Medicaid/Medicare	71.7
Uninsured	80
Patient community served	
Immigrants	51.3
Homeless	42.5
Farm workers	7.1
Incarcerated	7.1

Discussion

Overall, the survey results unsurprisingly suggest that providing care in safety net health centers is a cause of significant stress. A solid majority of those surveyed, especially those working full-time and those in rural areas felt that their work is a significant source of stress. Full-time status may be an unsurprising source of higher levels of stress; however, the reason for high stress in rural practices is less obvious. Items rated as high on the list for Table 2 show factors exacerbated by geographic isolation. For example,

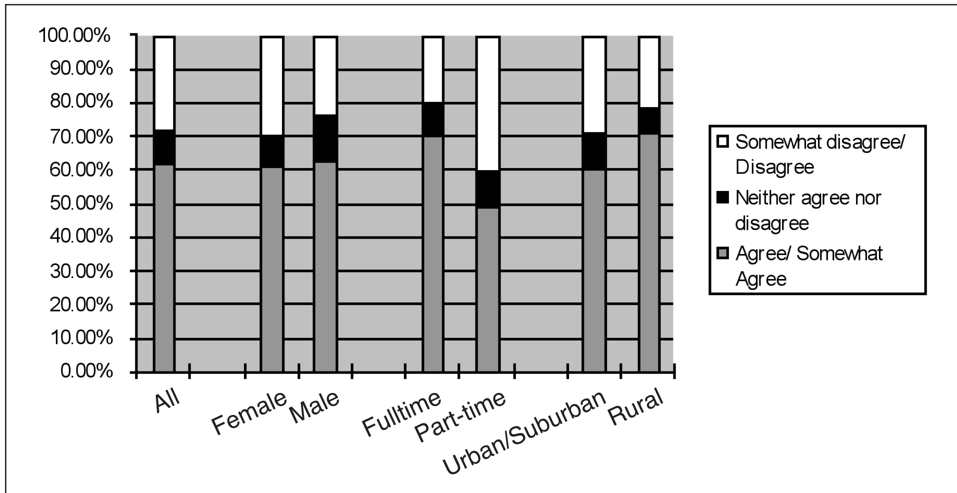

Figure 1. "My job is a significant source of stress in my life."

Table 2.

WORKPLACE STRESS RATING BY SOURCE

Sources of stress	Mean score[a]
1. Insufficient resources for my patients	3.65
2. Workload	3.65
3. Insufficient resources at my organization	3.43
4. Time to complete tasks	3.24
5. A strong base of referral networks for patients	3.2
6. Family responsibilities/work-life balance	3.13
7. Turnover in staff	3.12
8. Organizational structure	2.88
9. Sufficient team support to get my work done	2.82
10. Culturally appropriate resources for my patients	2.53
11. Language barriers with my patients	2.53
12. Salary	2.32
13. Supply stocks in exam rooms/work site	2.29
14. Support for professional development	2.2
15. Physical work environment	2.18
16. Organization of exam rooms/work site	2.14
17. Ability to find patient chart when needed	2.04
18. Relationships with coworkers	2.03
19. Job security	1.95
20. Benefits	1.88

[a]Scale: 1 to 5 with 1 being *least stressful* and 5 being *most stressful*.

Table 3.

CORRELATION OF THE LIKELIHOOD OF STAYING AT CURRENT ORGANIZATION/FIELD OF WORK AND STAFF/PRACTICE CHARACTERISTICS

	How likely are you to remain at your current organization in three years?	How likely are you to remain in the field of work in three years?
Staff characteristics	**Mean[a]**	**Mean[a]**
Male	3.11	3.74
Female	2.70	3.26
Full-time	2.60	3.38
Part-time	3.10	3.48
Urban/suburban	2.89	3.43
Rural	2.33	3.27
Wellness program- yes	3.02	3.56
Wellness program- no	2.65	3.31
Length of time in underserved care five years or less	2.76	3.35
Length of time in underserved care more than five years	2.86	3.46

[a]Scale: not at all likely = 1, somewhat likely = 2, very likely = 3, extremely likely = 4

insufficient resources for patient care may speak to large distances to needed services unavailable at the health center such as diagnostic services and specialty services. The lack of other safety net health centers in the area to share the demand for services from poor and underserved populations may be a principal issue in rural areas contributing to heavy workloads. Work-life balance was found to be high on the list and may speak to the lack of personal and family resources available to staff.

Despite the high levels and pervasiveness of stress among safety net workers, the majority of respondents believed that they would remain at their current organizations for three years. An even larger majority responded that they would remain working in underserved settings in three years. This shows the respondents' commitment to the underserved; however, many respondents (especially women, full-time staff, and those in rural areas) are considering leaving their current place of work. Part-time status, having a wellness program, and working more than five years in underserved care increase the likelihood of a person remaining at their current organization. Caution must be taken in drawing conclusions; for example, in the case of wellness programs, outcomes may reflect the organizational environment and leadership rather the direct

effects of the wellness program. Additionally, the length of time in underserved setting may have more to do with an individual's resilience to stress rather than the work environment.

This column highlights the commitment of those who work in underserved settings; however, additional investments are needed to recruit and retain such workers. Recruiters may want to emphasize the facets of such work that relieve stress rather than create it. Many safety net organizations provide generous fringe benefits, for example, such as extended vacation time and funds for continuing education to help recruitment and retention. Financial incentives such as federal and state loan repayment programs are also strong motivators. Policies and programs to provide additional health systems resources for patients, staff, and organizations may reduce stress especially for rural areas. Not only should more money go towards supporting technology such as telemedicine and electronic health records, but a coordinated effort to build local capacity is as important.

Finally, a major reason for the high levels of stress, according to our survey respondents is lack of resources for patients. Such a lack could be due to factors associated with a lack of comprehensive health insurance. Health insurance by itself is inadequate; however, making it universally available will begin to align the resources to address barriers to health care access. Universal health insurance coverage would create a steady stream of revenue and improve sustainability for safety net organizations that presently rely on a mosaic of grants. Furthermore, it is likely that under such a system clinicians would have expanded options for prescribing needed medicines and referring patients to specialists. This would improve quality of care for patients with chronic diseases because of improved adherence to needed medicines and access to specialty evaluations for end-organ damage. Women would be able to get mammograms more conveniently, and children would have better access to preventive services. Universal health insurance coverage would also improve equity in care, one of the main quality domains described by the Institute of Medicine.[8]

Enabling patients to receive needed services would relieve much clinician and staff stress, but changes in organizational structure and professional culture can also help. For example, using transdisciplinary approaches to staffing and decision-making fosters collaboration and innovation, especially in the complex clinical environments found in safety net organizations. Creative solutions, such as group visits for chronic disease where patients learn from peers as well as trained staff, can reduce the burden on the provider to be the sole source of health information. Support from leadership to allow more autonomy in clinical microsystems may improve efficiency and staff morale.

More women than men completed the ACU survey; however, this reflects growing trends in underserved settings, where women outnumber men.[9] Generally, full-time positions greatly exceed part-time positions at health centers, but survey respondents split evenly between the two categories (perhaps because part-time staff have more time to respond to surveys). The preponderance of urban location also shows skewed recruitment; according to the National Association of Community Health Centers 53 percent of federally qualified health centers are in rural areas.[10] Nevertheless, despite such skewing, the information obtained through the ACU survey is likely to reflect actual experiences of many in underserved care.

Clinicians and staff at safety net health centers are an indispensable part of the health care workforce that is often ignored. Any reform of the health system must assure that medically vulnerable and underserved communities continue to receive the needed care by supporting policies and program to recruit and retain these committed individuals.

Notes

1. Edwards D, Burnard P, Coyle D, et al. Stress and burnout in community mental health nursing: a review of the literature. J Psychiatr Ment Health Nurs. 2000 Jan; 7(1):7–14.
2. National Institute for Occupational Safety and Health. Exposure to stress: occupational hazards in hospitals. Cincinnati, OH: National Institute for Occupational Safety and Health, 2008. Available at: http://cdc.gov/niosh/docs/2008-136/pdfs/2008-136.pdf.
3. National Institute of Occupational Safety and Health. Stress at work. Cincinnati, OH: National Institute of Occupational Safety and Health, 1999. Available at: www.cdc.gov/niosh/stresswk.html.
4. Jennings BM. Work stress and burnout among nurses: role of the work environment and working conditions. In: Agency for Healthcare Research and Quality. Patient safety and quality: an evidence-based handbook for nurses. Rockville, MD: Agency for Healthcare Research and Quality, 2008. Available at: http://www.ahrq.gov/qual/nurseshdbk/.
5. Connoly C. In North Carolina, recession breeds a health-care crisis: job losses leave state with highest percentage of uninsured. Washington Post. 2009 Apr 20. Available at: http://www.washingtonpost.com/.
6. Dollard M, Winefield H, Winefield A, et al. Psychosocial job strain and productivity in human service workers: a test of the demand-control-support model. Journal of Occupational and Organizational Psychology. 2000;73(4):501–10.
7. Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52: 397–422.
8. Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press, 2001.
9. Weeks WB, Wallace TA, Wallace AE. How do race and sex affect the earnings of primary care physicians? Health Aff (Millwood). 2009 Mar–Apr;28(2):557–66.
10. National Association of Community Health Centers. Community health centers: meeting rural health needs. Fact Sheet #1108, January 2009. Available at http://www.nachc.org/client/documents/Rural_Health_Fact_Sheet_Final1.pdf.