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Impact of a RESET-based Pilot Program in a Family Medicine Clinic

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Abstract

This paper will explore if a Reward Efficiency, Set priorities, and Empower Teams (RESET) – based program implemented in the Family Medicine Department at a Military Treatment Facility in the Pacific Northwest improves outcomes of provider burnout, primary care manager (PCM) continuity, and access to care when compared to the usual state. A pre-post design was used. One Family Medicine team participated in the pilot program and the two remaining teams continued the usual state. Provider and staff burnout, PCM continuity, and access metrics were measured pre and post implementation. Burnout was measured through the Mini-Z burnout survey. T-tests were performed to compare change in overall staff burnout and PCM continuity between groups. Pre and post survey response rates were 80% and 90% with 20 paired participants across groups. There was not a statistically significant difference in staff burnout between groups. Post-implementation provider burnout level in the pilot group was 17% compared to 86% in the usual group. Both groups increased PCM continuity, without a statistically significant difference. A RESET-based model can positively impact provider burnout, PCM continuity, and patient access in a family medicine clinic. Further studies evaluating a fully implemented RESET program and quality indicators is needed.

Impact of a RESET-based Pilot Program in a Family Medicine Clinic

Introduction

Medical providers practice a profession that is fulfilling yet multifaceted and often stressful (Shanafelt et al., 2012). Daily demands often faced by medical professionals include complex decision-making, emotional demands, administrative tasks, electronic health record challenges, and long working hours (Shanafelt et al., 2012). These demands, especially when prolonged or excessive, can lead to burnout, which is defined as a state of physical and emotional exhaustion that often involves a sense of depersonalization and decreased personal accomplishment (Shanafelt et al., 2012).

In 2011, a national burnout survey was completed by over 7,000 physicians (Shanafelt et al., 2012). This survey revealed an average burnout level across all physician specialties of 45.8%, with a burnout range of 30-65% when assessing each specialty individually. Furthermore, evidence shows that higher burn out rates can lead to decreased provider productivity, decreased patient access, and decreased continuity (West, Dyrbye, Erwin & Shanafelt, 2016).

Root causes of dissatisfaction and burnout among providers include workflow, work control, and organizational culture (Linzer et al., 2013). Many primary care providers describe their work environment as chaotic, stressful, and inefficient (Gou, Chen, & Mehta, 2017; Linzer et al., 2009; Linzer et al., 2013; Hickson, Talbert, Thornberry, Penn, & Goodin, 2015; Roett & Coleman, 2013). These work environment challenges coupled with high patient access demands result in higher provider burnout rates (Linzer et al., 2009; Linzer et al., 2013; Nazi, 2013). However, improving provider perceptions of work control is shown to reduce symptoms of provider burnout (Linzer et al., 2013). This paper will describe the implementation of a

workflow system improvement program to address provider burnout, access to care and provider care manager continuity.

Significance of the Problem

Providers at the frontline of patient care are the most susceptible to symptoms of burnout. Family Medicine physicians rank as the fourth highest specialty for burnout with a level of 52% (Shanafelt et al., 2012). The only specialties with higher reported burnout levels are Emergency Medicine, Internal Medicine, and Neurology. The challenge of recruitment and retention of qualified providers in these specialties is beginning to be recognized by healthcare leaders as a significant issue that needs proactive and effective interventions (Linzer et al., 2013; Shanafelt et al., 2012).

High levels of provider burnout can contribute to negative consequences in provider health, the healthcare system, and ultimately, patient care (West, Dyrbye, Erwin, & Shanafelt, 2018). Evidence suggests that providers may experience decreased self-care, decreased work effort, decreased professionalism, self-perceived increase in medical errors, mental health concerns, and suicidal ideation (West, Dyrbye, Erwin & Shanafelt, 2016). These challenges can result in reduced provider productivity, increased staff turnover, decreased patient access, and increased costs (West, Dyrbye, Erwin & Shanafelt, 2016).

The consequences of burnout can lead to decreased patient perceptions of care quality and satisfaction, lower care quality, and medical errors (Perzynski, Caron, Margolius & Sudano Jr., 2018, West, Dyrbye, Erwin, & Shanafelt, 2018). These outcomes are seen nationwide, in both rural and urban healthcare settings, including civilian, Veterans Affairs, and military health centers (Edwards, Kim & Stockdale, 2017; Sargent et al., 2016; Shanafelt et al., 2012).

Background

The Naval Hospital Bremerton (NHB) Family Medicine clinic encountered significant challenges in Fall 2017, including high staff turnover and the introduction of a new electronic health record (Fortunato, Torres & Sheehy, 2018). Additionally, NHB was still adjusting to the recent Bureau of Medicine and Surgery mandated restructuring of services that occurred in 2016, including closure of the Family Medicine Residency Program, transforming the Emergency Department into an Urgent Care Clinic, and eliminating the Intensive Care Unit (Stutz, 2016). At the same time, Family Medicine leadership recognized low staff satisfaction, a decrease in patient access, and a decrease in Primary Care Manager (PCM) continuity (Fortunato, Torres & Sheehy, 2018).

At the request of local leadership to further explore staff satisfaction concerns, a Mini-Z Burnout survey was administered to all Family Medicine staff members in December 2017 (Fortunato, Torres & Sheehy, 2018). This survey had an overall 70% response rate and a 100% provider response rate. Based on a 5-point Likert scale, the survey results indicated that providers had the highest average stress rate of 83%. Nurses had average stress rates of 33% and medical assistants (MAs) and corpsman had average stress rates of 47%. Providers also had the highest average reported burnout rating, averaging 70%, with nurses, MAs, and corpsman averaging burnout rates of 50%.

To address these concerns, NHB stakeholders conducted a literature review to determine an effective and measurable intervention to improve both patient access and address provider burnout (Fortunato, Torres & Sheehy, 2018). They concluded that introducing templated virtual appointments as a demand management tool would likely improve the metrics of patient access and efficiency within the Family Medicine Department. To implement templated virtual

appointments and with buy-in from local leadership, NHB Family Medicine began researching the RESET (Reward Efficiency, Set Priorities, Empower Teams) program and planned for pilot implementation in September 2018 (Fortunato, Torres & Sheehy, 2018).

Piloted at the Family Medicine clinic at Ramstein Air Force Base beginning July 2017 and implemented in more than 75% of Air Force Medical clinics worldwide, the RESET program was designed to improve clinical workflow, increase patient access, improve staff satisfaction, and reduce provider burnout (Lutz, Fletcher, Hubbard & Rottweiler, 2018). The program provides a systematic tool for implementation with measurable objectives.

Ramstein's Family Medicine clinic significantly improved metrics of access and staff satisfaction in the first year of implementation (Lutz, Fletcher, Hubbard & Rottweiler, 2018). From pre-RESET implementation (August 2016 – December 2017) to post-RESET implementation (January 2018 – June 2018), access (defined as future appointments, third next available) improved from 8.52 to 4.42, virtual appointments increased from zero to 3, 473, and the clinic had the lowest reported staff burnout rate, by 37%, of all clinics measured in the Air Force Medical Services. As of July 2018, the clinic converted 18% of appointments to virtual appointments.

Clinical Question

"Will a RESET-based program in the family medicine department improve outcomes of provider burnout, provider-patient continuity, and access to care when compared to the usual state?"

Focus Areas

The four main focus areas of this evidence-based project align with the steps described in the Iowa-Based Model of Evidence-Based Practice (Doody & Doody, 2011; Iowa Model

Collaborative, 2017). See table B3 for details. The focus areas include: identify an issue, appraise the evidence, pilot the practice change, and evaluate the practice change.

Relevance to military nursing

The challenges, best practices, and lessons learned from this implementation of a RESET-based model using Military Health System (MHS) Genesis can be shared with other Military Treatment Facilities (MTFs) as they transition to MHS Genesis and consider new workflow processes. Several MTFs have already reached out to NHB leadership inquiring about the MHS Genesis transformation (M. Hoefler, personal communication, September 20, 2018).

Additionally, increasing clinical efficiency allows Family Medicine clinics to get ahead of the curve on the transformation of the MHS to full Defense Healthy Agency (DHA) oversight, whose goal, mandated by the fiscal year 2017 National Defense Authorization Act, is to integrate and standardize military medicine across all branches and facilities (McCaffery, 2019). Full integration including all overseas hospitals is expected by October 2021. Daily access metric goals for MTF primary care clinics to template a total of 100 appoints per week per full-time provider (Defense Health Agency [DHA], 2018a). Providers can accomplish this metric by completing 20 appointments per workday, templated as 16 face-to-face appointments and four virtual appointments.

Organizing Framework

Developed in 1994, the nursing community uses the Iowa-Based Model of Evidence-Based Practice as a framework for evidence-based practice to promote high quality and up to date clinical practices (Doody & Doody, 2011; Iowa Model Collaborative, 2017). The most recent version of the Iowa Model outlines seven steps with three decision points to organize a

systematic approach to incorporate evidence into practice (Iowa Model Collaborative, 2017). See Table 1 for the application of the Iowa-Based Model of Evidence-Based Practice to this project.

Project Design

General Approach

A pre-post design was used to evaluate if a RESET– based pilot program improves outcomes of provider burnout, PCM continuity, and access to care when compared to the usual state.

Setting

NHB is a community-sized hospital with three family medicine teams located in the Pacific Northwest. See table B1 for a description of staffing within the department at the baseline of the evaluation period.

Procedural Steps

Phase I - Issue Identification

Family Medicine leadership identified high levels of staff and provider burnout in conjunction with declining metrics of access to care and PCM data (Fortunato, Torres & Sheehy, 2018). In December 2017, Fortunato, Torres & Sheehy (2018) administered the Mini-Z Burnout survey to all Family Medicine staff members. Survey results indicated an overall provider burnout average of 70%, with nurses, medical technicians, and corpsman averaging burnout rates of 50% based on a 5-point Likert scale. In June 2017, access to acute care appointments (goal is 1.0 day or less) was 0.51 and access to routine care appointments (goal is seven days or less) had dropped from 1.46 (April 2017) to 3.52 (June 2017) (DHA, 2018a; DHA, 2018b). From April 2017 to August 2017, PCM continuity decreased from 60% to 54.1% (goal is 70% or higher) (DHA, 2018b).

Phase II - Appraise the Evidence

Project authors completed a site visit and literature appraisal. The site-visit to Air Force Base Fairchild Pediatric clinic allowed observation of a clinic using both MHS Genesis and the RESET program. The authors completed field notes and disseminated best practices to NHB leadership (see Table B2). A literature review was conducted to assist in RESET program implementation and evaluation at NHB. This review focused on the concepts of workflow and virtual care and nine pertinent articles were synthesized (see Appendix A for PRISMA diagram).

Literature review findings support that a virtual health driven workflow may reduce provider burnout (Gou et al., 2017; Linzer et al., 2009; Linzer et al., 2013; Nazi, 2013; Shaw et al., 2017) and improve provider assess and care continuity (Hickson et al., 2015; Nazi, 2013; Roett & Coleman, 2013). The most common benefits of virtual health appointments reported are improved provider perception of workflow control and reduced provider burnout (Gou et al., 2017; Linzer et al., 2009, Linzer, et al., 2013; Nazi, 2013; Shaw et al., 2017), improved efficiency and clinical workflow (Hickson et al., 2015; Nazi, 2013), and improved care continuity, patient and provider communication, and provider access (Hickson et al., 2015; Nazi, 2013; Roett & Coleman, 2013).

The most common risks of virtual health appointments reported include the lack of evidence assessing patient health outcomes and satisfaction (Hickson et al., 2015), the lack of evidence-based implementation guidelines (Nazi, 2013), and the lack of evidence demonstrating a reduction in the need for face-to-face visits with the use of virtual health appointments (Nazi, 2013; North et al., 2014). Studies emphasize the importance of provider perceived relevance and value, a comprehensive provider education and training program, provider incentives, and the integration of technology into existing workload as critical elements in the plan to implement

virtual health appointments (Linzer et al., 2013; Nazi, 2013; Shaw et al., 2017; Roett & Coleman, 2013; Young & Nesbitt, 2017).

The RESET program concept of operations was also appraised prior to pilot program implementation. The three main concepts of the program are rewarding efficiency, setting priorities, and empowering patient care teams. The first concept, rewarding efficiency, is met through increasing team flexibility and self-governing. The team works to decrease the demand for face-to-face visits by enhancing other ways to provide patient care such as virtual appointments, secure messaging, and group appointments. As the provider's face-to-face schedule decreases, the team may receive a reward of a "golden day" off from the clinic or administrative time for professional development. Rewarding efficiency with a "golden day" off creates value, value increases motivation, and motivation feeds staff innovation (Lutz, Fletcher, & Hubbard, 2018).

The second key concept of RESET is setting clear and measurable priorities to meet required metrics which include the following: patient access, staff satisfaction, patient satisfaction, secure messaging utilization, panel ownership, emergency room/urgent care utilization, and other pertinent long-term goals as determined by the local command (ie. HEDIS goals). Team members objectively measure these priorities via the RESET scorecard, increasing transparency and accountability of all team members (Lutz, Fletcher, & Hubbard, 2018).

The final concept, empowering teams, provides healthcare teams the autonomy and time to meet the needs of their patient population innovatively. Individualized template management and virtual health appointments empower team members by increasing their scheduling control. Virtual appointments are conducted as either a secure messaging or as a telephone conversation between the patient and the provider. Team members virtual scrub provider schedules by

evaluating future booked face-to-face appointments and determining which can be converted to a virtual appointment. Patients receive earlier access and demand for future appointments is reduced (Lutz, Fletcher, & Hubbard, 2018). Adding virtual health appointments can enhance access by providing alternate forms of patient-provider communication (Jackson et al., 2013; Varga, Lombardi, & Maio, 2016).

Phase III - Piloting the Practice Change

NHB leadership developed a modified version of RESET for pilot intervention. This version emphasized virtual scrubbing and virtual health appointments. Local leadership finalized a start date of Sept 4, 2018 for the RESET-based pilot program for one of three Family Medicine teams. Team one (the RESET-pilot team) of the Family Medicine department was chosen by local leadership to pilot the RESET-based program because of their consistency in meeting DHA metric requirements (M. Hoefler, personal communication, September 20, 2018). The two other family medicine teams continued with the usual state of 16 daily face-to-face appointments with less emphasis on scrubbing schedules and virtual health appointments. Instead of the "golden day" off reward, the modified RESET-based program would offer self-governing provider scheduling as the reward. The RESET-pilot team received training on schedule scrubbing and virtual health appointment scheduling prior to implementation from local leadership and on-site trainers.

Phase IV - Evaluating the Practice Change

The metrics of burnout, access, and PCM continuity were used to evaluate the effectiveness of the modified RESET-based pilot program (see table B4 for definitions). The Mini-Z burnout survey was distributed to all Family Medicine staff members pre and post pilot program implementation in August 2018 and December 2018. The surveys were given by hand,

collected in-person, and each contained a unique identifier code to complete matched paired analysis. This survey was chosen due to its relevance to workflow process improvement projects in primary care clinics (Linzer et al., 2000; Linzer et al., 2009; Schmoldt, Freeborn & Klevit, 1994; Williams et al., 2001). The specific burnout question on the survey was adopted from Freeborn's tedium index and is validated against the Maslach Burnout Inventory or MBI (Rohland & Rohrer, 2004; Schmoldt, Freeborn, & Klevit, 1994).

The metrics of access and PCM continuity were analyzed for alignment with the Patient-Centered Medical Home (PCMH) outcomes and DHA access metrics (Arend, Tsang- Quinn, Levine & Thomas, 2012; DHA, 2018b; Jackson et al., 2013). The metrics of access to care and PCM continuity were evaluated for a period of three weeks in August (August 6-August 24, 2018), just prior to the RESET-based pilot, and again for a period of three weeks in December (December 3-December 21, 2018) three months after the RESET-based pilot program.

Access data was analyzed with the assistance of the NHB business office, whom, in alignment with DHA guidelines, uses the 3rd next appointment availability to calculate metrics for both same day and future appointments. The third next available appointment is defined as the average length of time in days between the day a patient makes a request and the third next available appointment. For appointment data, the number 1.0 equals 24 hours. The same day appointment DHA access goal is less than 1.0 and the future appointment access goal is less than seven days. PCM continuity was measured via a built-in EHR report was analyzed to determine the percentage of times a provider saw their own empaneled patients in the three-week period before the RESET-based pilot compared to the three-week period following the RESET-based pilot program.

The independent variables include the RESET-based program and the usual state. Measured outcomes include staff burnout, access to care, and PCM continuity (see table 3 for outcomes definitions). Independent Sample T-testing was used to analyze the average change in outcomes for the pilot team compared to that of the usual care teams.

HIPAA Concerns

NHB's commanding officer approved this project. The priority legal considerations for this project include the development of Clinical Practice Guidelines (CPGs) and adherence to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. All individually identifiable health information was de-identified. Project members stored data on a CaC-enabled computer in a locked room (LoBiondo-Wood & Haber, 2014).

Analysis of Project Results

The results consist of both the descriptive and statistical findings for the metrics of burnout, access, and continuity. Descriptive data from survey responses were analyzed to determine the clinical relevance of the RESET-based pilot program. The descriptive survey data includes all staff who completed both pre and post surveys. Due to staffing changes and survey participation, there is a degree of variation in the pre and post sample size descriptive data. The pre-intervention response rate was 80% (n=47/59) and the post-intervention response rate was 90% (n=57/63). Although the burnout question is the most detailed survey question, it was the most frequently skipped question, resulting in pre-intervention response rate of 63% (n = 37/59) rate and post-intervention response rate of 71% (n=45/63).

Statistical analysis was completed to determine the generalizability of burnout and continuity findings. For inclusion in the burnout analysis, participants must have answered the burnout question on pre and post-RESET-pilot surveys and remained in the same group during

the evaluation period; statistical analysis was completed for 20 matched paired surveys (n of 9 from the RESET-pilot group and n of 11 from the usual group).

Demographics

Table B5 provides the demographics of survey participants used in statistical analysis including the participants' role (physician, nurse practitioner/ physician assistant, nurse, medical technician/ corpsman), military or civilian rank, and gender. Demographics were relatively equal between the two groups; the only notable difference was an additional provider and two additional technicians in the usual state group.

Burnout

The burnout level for support staff (nurses and medical technicians/ corpsmen) on the RESET-pilot team was 45% (n=11) pre-RESET pilot and 31% (n=13) three months post-RESET pilot. Burnout levels for support staff continuing the usual state was 81% (n=16) baseline and 47% (n=19) three months later. See table B6 for details.

A provider subset was analyzed because the Mini-Z Burnout survey is designed to evaluate physician burnout and the RESET program relies on a substantial provider practice change (Linzer et al., 2000; Linzer et al., 2009; Lutz, Fletcher, Hubbard & Rottweiler, 2018). The burnout level for providers (physicians, nurse practitioners, and physician assistants) on the RESET-pilot group was 100% (n=3) pre-RESET pilot and 17% (n=6) post-RESET pilot. Burnout levels for providers continuing the usual state was 100% (n=5) at baseline and 86% (n=7) three months later. See table B7 for details.

An independent-samples t-test was conducted to compare the change in burnout ratings for all staff members (providers, nurses, medical assistants, and corpsmen) between the RESET-pilot group and the usual state group. Nine participant surveys for the REST-based pilot group

and eleven participant surveys from the usual group were analyzed. There was no significant difference in the change in burnout ratings for the usual group (M= -.36, SD=1.01) and RESET group (M=.33, SD= 1.12; t (18) = -1.45, p= .16, two-tailed). Assumptions for sample size were not met to complete independent-samples t-test for the change in burnout in the provider subset.

Access

The pilot team had the following access findings from pre to post implementation: same day appointment access time lengthened from an average of 0.15 to 0.22 and future appointment access time decreased from an average of 9.99 to 1.63, and virtual appointments increased in quantity from five to 95. For the same period, the usual group had the following access findings: same day access time lengthened from an average of 0.1 to 0.19 and 0.1 to 0.2 and future access time lengthened from an average of 2.06 to 3.0 and 1.9 to 2.52. See Table B8 – B10 for details. Virtual appointment numbers were not analyzed for the usual state teams because virtual appointments were not yet implemented.

PCM Continuity

Baseline PCM continuity for the RESET-pilot group was 57.6% (n=5) and increased to 77.7% (n=6) three months following the RESET pilot. Baseline PCM continuity for the usual state group was 68.3% (n=8) and increased to 80.6% (n=10) three months after continuing the usual state. See table B11 for details. Independent-samples t-test was conducted to compare the change in PCM continuity for the RESET-based pilot group to the usual group. There was no significant difference in the change in PCM continuity for the RESET-based pilot group (M = -.24, SD = .16) and the usual group (M = -.13, SD = .08; t (13) = 1.58, p = .14, two-tailed).

Discussion of the Results

Burnout

A notable project finding was that support staff on the RESET-based pilot group started at almost half the burnout level of the usual group. The staff on the RESET pilot group experienced a 14% reduction in burnout, while the staff on the usual group experienced a 34% reduction in burnout. The more dramatic change in staff burnout for the usual group may have been influenced by a departmental leadership change and staff turnover during the RESET pilot. Ultimately, staff on the RESET-pilot group experienced a lesser level of burnout in the pre and post intervention periods when compared to staff continuing the usual state.

The pre-RESET sample size of three providers on the RESET-based pilot group makes the reported level of burnout of 100% less useful. In the post-RESET period, all six providers in this group completed the burnout question with a reported level of burnout at 17%. The providers continuing with the usual state reported a baseline burnout level of 100% and a final burnout level of 86%, representing only a 14% reduction in burnout during the three-month evaluation period. Despite the sample size of three providers for the baseline burnout level for the RESET pilot team, the 69% higher level of provider burnout for the usual state providers compared to the RESET-based pilot group at the end of the evaluation period is clinically significant. For perspective, the final burnout level of 17% for the RESET-pilot providers is well below the national average of 52% burnout among Family Medicine physicians (Shanafelt et al., 2012). The usual state providers remain well above this national average with a final burnout level of 86%.

Access

All of the Family Medicine teams were meeting the same day metric of less than one day pre-RESET, and all of the teams had a comparatively small increase in time for same day appointments post-RESET, equaling an increase in time of approximately one to two hours. All three teams met the DHA metric goal of less than one day for a same day appointment before and after the implementation of RESET.

PCM Continuity

PCM continuity exceeded the DHA metric goal of 70% in both groups during the RESET evaluation period. A 20.1% improvement in PCM continuity was noted for the RESET-based pilot group, while a 12.3% improvement was noted for usual state group from the pre-RESET to the post-RESET period. The small improvement in PCM continuity for the RESET-pilot team was ultimately not statistically significant when comparing matched paired data.

Confounding Variables

Several confounding variables may have influenced the outcome of the RESET-based pilot at NHB. Staff turnover and the change in departmental leadership during the evaluation period may have influenced some of the overall survey trends. Survey participants knew they were being evaluated which may have influenced survey responses, particularly in the RESET-pilot group. Despite the high survey response rate, only 20 out of the original 59 participant surveys were statistically analyzed. The low level of matched paired surveys (n=20) resulted from a high number of personnel changes during the RESET-based pilot evaluation period and a low response rate to the burnout question. The RESET-based pilot did not indicate a statistically significant difference in change of staff burnout or PCM continuity for the RESET pilot group

compared to the usual state. The significance values, however, may be misleading given the small sample size of this pilot (n=20 for burnout, n=13 for continuity) (Pallant, 2013).

When analyzing access and continuity data, it was not possible to find pre and post pilot program periods with identical provider staffing due to variations in vacation time and on-call schedules. The authors did attempt to mitigate this by selecting periods with similar provider schedules. Additionally, the authors did not analyze continuity data for providers that changed teams during the evaluation period because MHS Genesis only reflects real-time PCM assignments.

Organizational Impact / Implications to Practice & Policy

Although these results cannot be generalized, the findings indicate that a RESET-based program aimed at enhancing the use of virtual scrubbing and virtual appointments does not negatively impact metrics of staff burnout, access to care, or PCM continuity. Furthermore, the results indicate that this local RESET-based program significantly improved provider burnout below the national level among Family Medicine physicians (Shanafelt et al., 2012).

These findings represent a clinically significant impact because it provides evidence that a locally developed RESET-based program has the potential to reduce provider burnout while still being able to meet and potentially improve PCMH and DHA metrics of access and PCM continuity. These findings align with the literature appraisal that found that higher burnout rates among providers can lead to decreased provider productivity, decreased patient access, and decreased continuity (West, Dyrbye, Erwin & Shanafelt, 2016).

Based off our literature review and RESET-pilot evaluation, we recommend the consideration of using a theoretical framework to guide the implementation process of future pilot programs. For example, Roger's Diffusion of Innovation Theory, provides a systematic

approach that would assist in gaining staff buy-in for technology integration (Lee, 2004; Rogers, 1995).

Future Directions for Research and Practice

Related studies recommend future research involving higher-level studies evaluating the impact of virtual health appointments on patient and provider satisfaction, efficiency, and health quality indicators (Hickson et al., 2015; Nazi, 2013; Linzer, 2009). There is a lack of studies focusing on evidence-based implementation strategies or cost or feasibility analysis (Gou et al., 2017; Hickson et al., 2015; Linzer et al., 2009; Linzer et al., 2013; Nazi, 2013; North et al., 2014, Roett & Coleman, 2013, Shaw et al., 2017; Young & Nesbitt, 2017). Lastly, there is a need for future research studies that evaluate a fully implemented RESET program that includes the reward component. There is gaining consensus for a large-scale, standardized, proof of concept of the fully-implemented RESET model to provide DHA higher quality data on the program and its results (S. Fletcher, personal communication, March 8, 2019).

Conclusion

Our project findings support the evidence that a RESET-based program that emphasizes the use of virtual scrubbing and virtual appointments has the potential to improve provider burnout without decreasing metrics of access to care and PCM continuity in a family medicine clinic. The project has paved the way in creating the body of evidence to support a RESET model in Navy Medicine clinics.

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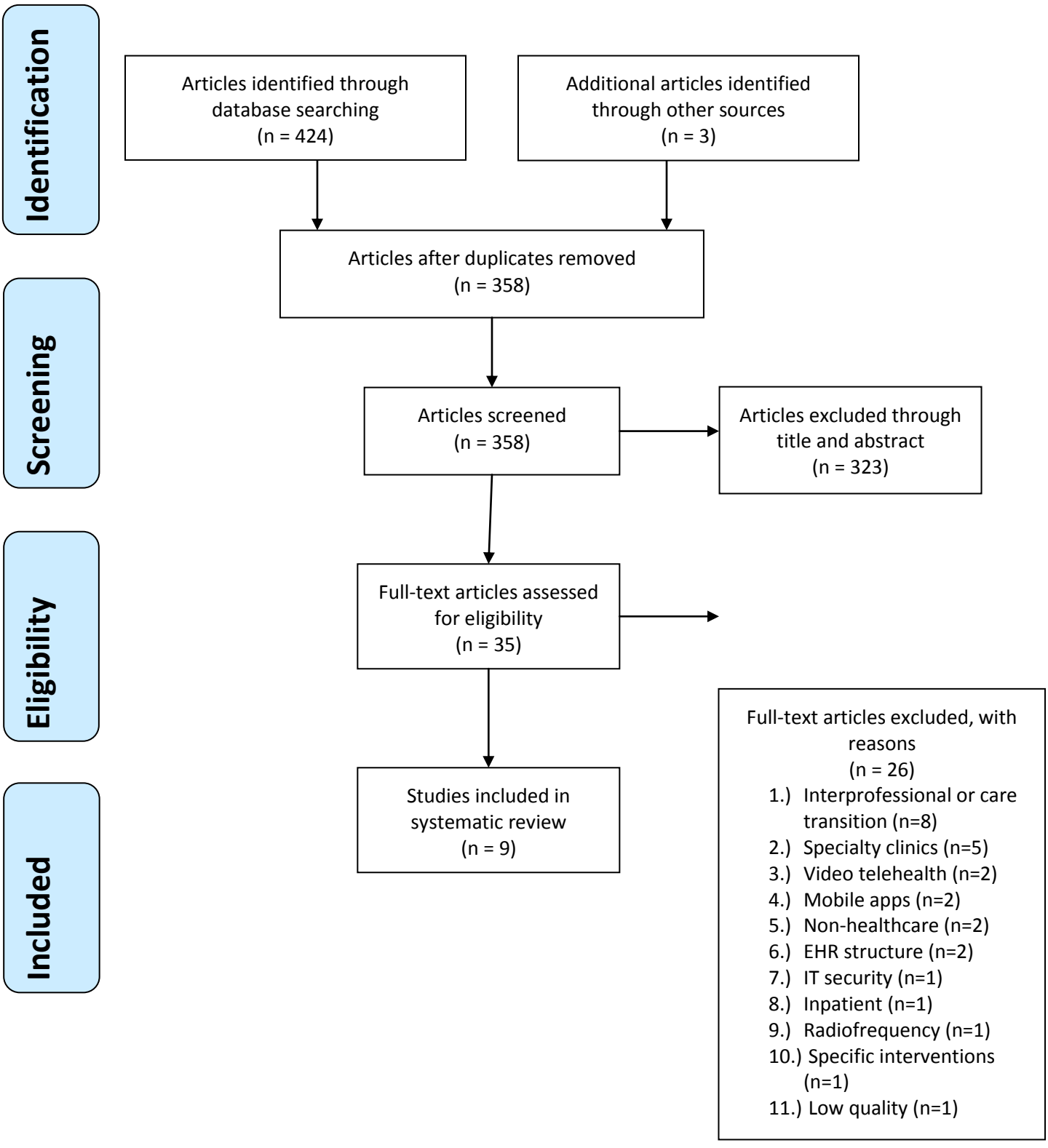
Appendix A

PRISMA 2009 Flow Diagram



(Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2009)

Appendix B

Table B1

Naval Hospital Bremerton Family Medicine Department Staffing

	Providers	Nurses	Medical Technicians and Corpsmen
RESET-based Pilot Group	6	3	15
Usual state group	8	6	22

Table B2

Site visit RESET best practice recommendations

1. Localized call center promotes better communication of intent and availability of virtual appointments.
2. All staff have ability to change face-to-face appointments with virtual appointments.
3. All telephone consults are tracked and documented as virtual appointments.
4. Steps to generate reports showing virtual appointment usage.
5. Providers give “proxy” status to support staff for building encounter notes, message center management, and virtual appointment scheduling.
6. Future considerations to track Health Outcomes (ie- HEDIS metrics) related to RESET.

Table B3

Steps of the Iowa-Based Model for Evidence-Based Practice Change

Step 1: Identifying Triggering Issues / Opportunities	- Dec 2017 Mini-Z survey results indicate a 70% provider burnout and 50% staff burnout on a five-point Likert scale (Fortunato, Torres & Sheehy, 2018). - Access to routine care appointments dropped from 1.46 days (April 2017) to 3.52 (June 2017) (goal is seven days or less) from April 2017 to June 2017 (Defense Health Agency, 2018b). - Primary care manager continuity decreased from 60% to 54.1% (goal is 70% or higher) from April 2017 to August 2017 (Defense Health Agency, 2018b).
Step 2: Identify the Question	Will a RESET – based program in the family medicine department improve outcomes of staff burnout, provider care manager continuity, and access to care when compared to the usual state?
Step 3: Form a Team	- The team of stakeholders includes three DNP students, Family Medicine Department Head, Chief Medical Informatics Officer, physician champion, an off-site faculty member, and an on-site faculty member who is also a practicing provider in the clinic
Step 4: Assemble, Appraise and Synthesize Body of Evidence	- Conduct site-visit to Air Force Base Fairchild Pediatric clinic to observe the RESET program live in MHS Genesis. - Sufficient evidence, determined by the quality, quantity, consistency, and risk identified in the literature search, exists for a practice change.
Step 5: Design and Pilot the Practice Change	-Project champions develop plan to pilot RESET program - Collect baseline data on staff burnout, access to care, and provider care manager continuity. - Pilot the RESET program on one family medicine team beginning September 3, 2018. - Collect burnout, access, and continuity data 3 months following the pilot of RESET. - Determine if data supports adoption of RESET across the three family medicine teams.
Step 6: Integrate and Sustain the Practice Change	- Report findings to executive board. NHB Family Medicine adopts RESET program on all three teams. Continue program evaluation by recommending continued evaluation of burnout, access, and continuity.
Step 7: Dissemination	-Present EBP project during Uniformed Services University research week and the Tri-service Nursing Research Program

Table B4

Glossary of terms

Outcomes	**Definitions**
Staff Burnout	Defined by participates self-rating of burnout. The Mini-Z survey question ask participants to rate burnout by the following criteria: a. I enjoy my work, I have no symptoms of burnout b. I am under stress, and don't always have as much energy as I did, but I don't feel burned out c. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion d. The symptoms of burnout that I am experiencing won't go away. I think about work frustrations a lot e. I feel completely burned out. I am the point where I may need to seek help Burnout is defined by responses of either c, d, or e
Access to care	Defined by the 3rd next available appointment for acute and routine care for a three-week period of time at baseline and three-week period of time three months after the pilot of RESET
Provider care manager continuity	Defined by the number of encounters with empaneled patients for the PCM over the PCM's total number of encounters (impaneled and non-impaneled) for a three-week period of time at baseline and three week period of time three months after the pilot of RESET

Table B5

Demographics

	Role	Rank	Gender
RESET-based Pilot Group	2 providers 1 nurse 6 technicians	2 officers 5 enlisted 2 civilians	5 males 4 females
Usual State Group	3 providers 0 nurses 8 technicians	2 officers 7 enlisted 2 civilians	7 males 4 females

Table B6

Mini-Z Burnout Survey Results: RN/MA/HM/Support Staff Burnout

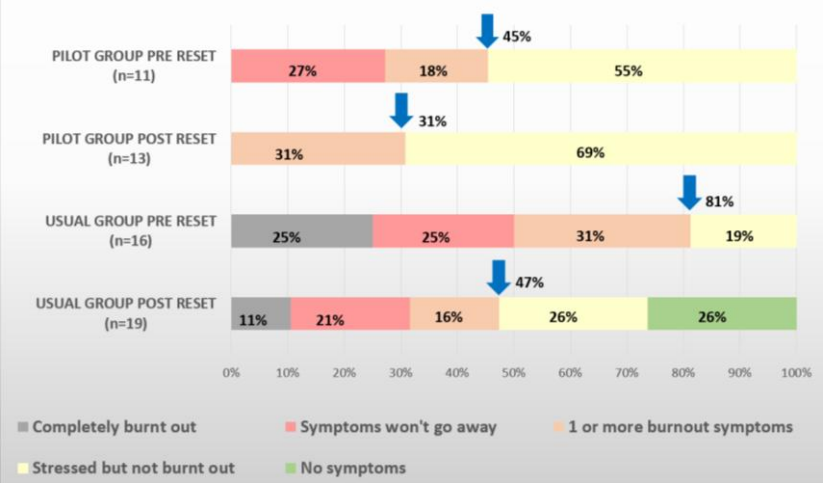


Table B7

Mini-Z Burnout Survey Results: Provider Level of Burnout

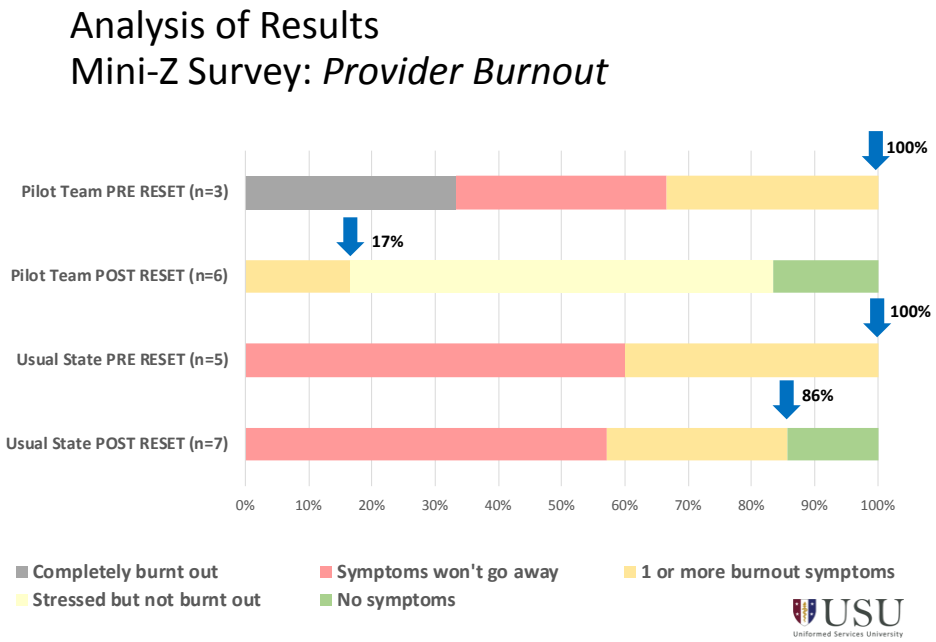


Table B8

Access to Care: Same Day Appointments

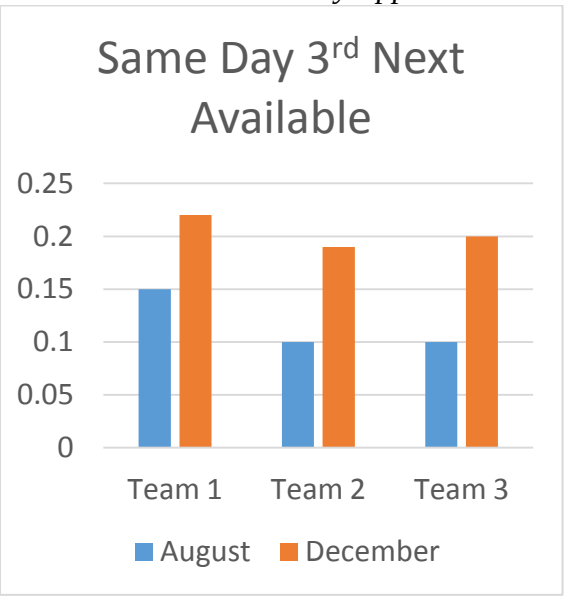


Table B9

Access to Care: Future Appointments

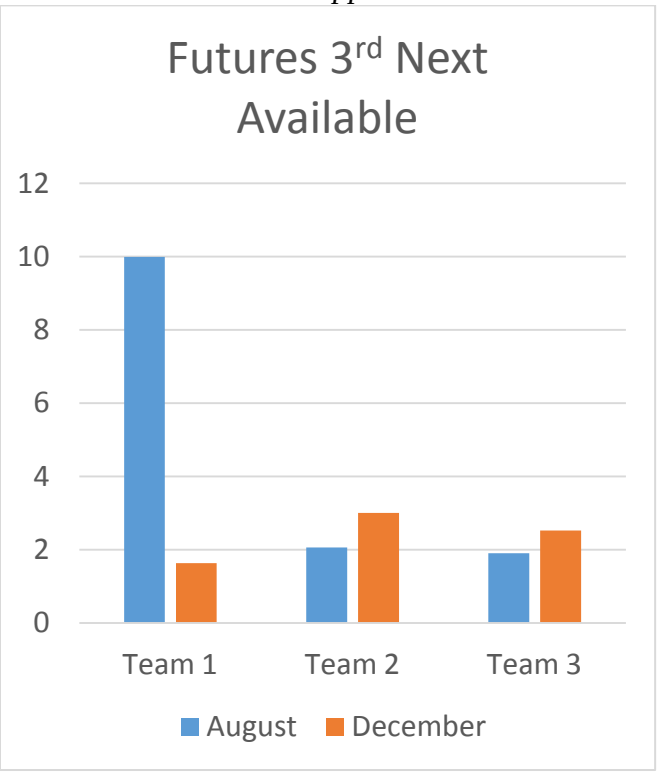


Table B10

Virtual Appointments for RESET Providers

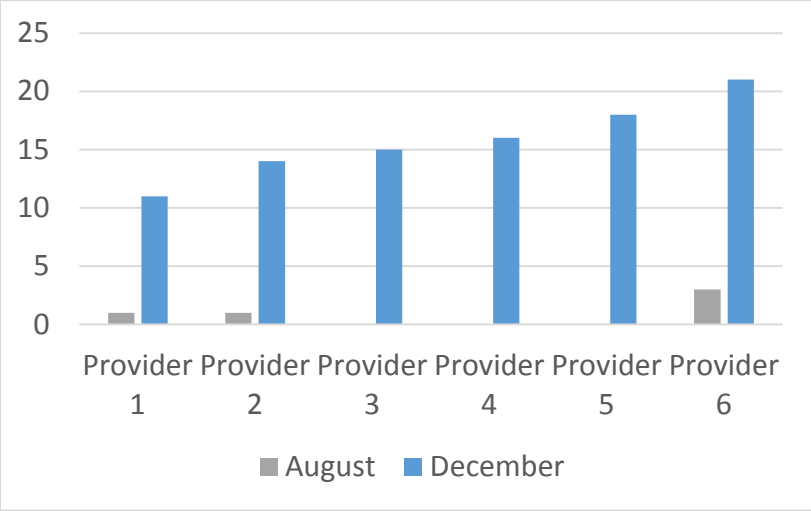
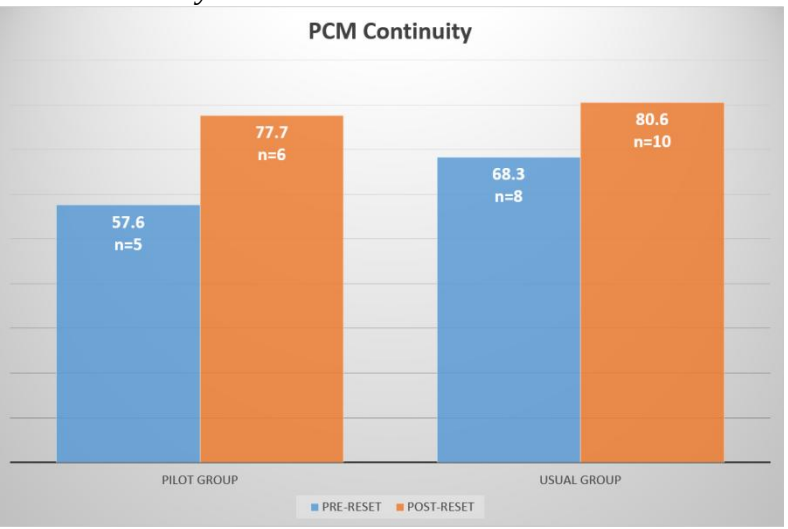


Table B11

PCM Continuity



Appendix C

CITI Certificates for all students

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Kara McDowell (ID: 5735134)
- **Email:** kara.mcdowell@usuhs.edu
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Phone:** 8162257380

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 20598975
- **Completion Date:** 26-Aug-2016
- **Expiration Date:** 26-Aug-2019
- **Minimum Passing:** 80
- **Reported Score*:** 89

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Crystal Aandahl (ID: 5736117)
- **Email:** crystal.aandahl@usuhs.edu
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Phone:** 7608450079

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 20602238
- **Completion Date:** 26-Aug-2016
- **Expiration Date:** 26-Aug-2019
- **Minimum Passing:** 80
- **Reported Score*:** 100

Appendix D

USU (VPR) Form 3202N (final copy from USU (VPR)

USU
Uniformed Services University

OFFICE OF RESEARCH
4301 JONES BRIDGE ROAD
BETHESDA, MAYLAND 20814
PHONE: (301) 295-3303; FAX: (301) 295-6771

NOTICE OF PROJECT APPROVAL
Change Number: Original

VPR Site Number:	T0-GSN-61-9982-01
Principal Investigator:	Ziezulewicz, Amy
Department:	Graduate School of Nursing
Project Type:	Student
Project Title:	Implementation of a Provider-Based Educational Tool to Improve Virtual Appointment and secure Messaging Utilization
Project Period:	7/31/2018 to 7/31/2019

Assurance and Progress Report Information:

Name	Sup	Approval Type	Status	Approved On	Forms Received
Progress Report	0		Final	To be Submitted	N/A

Remarks:
This Notice of Project Approval has been reviewed and approved. Please remember that you must submit a final Progress Report (Form 3210) upon completion of this project.

Questions regarding this approval should be directed to the following person in the Office of Research:
Sharon McIver, (301) 295-9814.

[redacted]

Yvonne T. Maddox, Ph.D. Date
Vice President for Research
Uniformed Services University of the Health Sciences

Appendix E

MTF IRB/PI Letter of Determination

PI Approval Form

NMCSD.QI.2019.0009

INTENT TO ENGAGE IN PERFORMANCE IMPROVEMENT PROJECT INVOLVING LIVING HUMAN BEINGS OR IDENTIFIABLE PATIENT INFORMATION

Complete and submit this form to Dr. Elisea Avalos-Reyes when an investigator proposes a performance improvement project involving humans that s/he does not believe constitutes human subject research. The investigator must provide adequate information for the IRB Chair/ Vice Chair and/or delegate to determine whether the project constitutes human subject research. If the reviewer determines that a project is not human subjects research, the IRB will have no on-going involvement with the project. If the project is deemed to meet the definition of human subject research, a complete IRB submission will be required.

A data sharing agreement checklist must also be included in this submission. Contact the Clinical Investigation Department or Dr. Elisea Avalos-Reyes for the most recent version.

Be as specific as possible when answering the below questions.

Rank, Designation and/or Degree:

Investigator Name (LAST, FIRST):

Savage, Assanatu	CDR, 2900, DNP/ PhD

E-mail: Phone Number:

assanatu.i.savage.mil@mail.mil	360-475-5095

Command: Department:

Naval Hospital Bremerton	Family Medicine

Project Title:

A Reward Efficiency, Set Priorities, and Empower Teams (RESET)-Based Model

1. Describe the problem that this project will identify and improve. Specifically mention the population/ program and provide the background, evaluation, and method of implementation.

The PICOT question for this quality improvement project is: Will a Reward Efficiency, Set priorities, and Empower Teams (RESET)-based program in the family medicine department improve metrics of enhanced access, care continuity, and staff reactions when compared with usual care?

For purposes of this project, the term "providers" includes family medicine physicians, nurse practitioners, and physician assistants. The term "family medicine staff" includes family medicine providers, nurses, corpsman, and medical technicians. The metric of enhanced access will be measured by the number of weekly virtual appointments completed by each family medicine provider. The metric of care continuity will be measured by the number of cross-booked appointments between family medicine providers. Family medicine staff reactions will be measured by perceived levels of job satisfaction, job stress, and burnout on the Mini-Z Burnout survey.

Population: The population is three teams of staff in the family medicine department at Naval Hospital Bremerton.
The RESET program will be implemented on Team 1. Teams 2 and 3 will continue with current patient-centered medical home workflow practice. No patient interaction will be required. Data collection does not contain PHI.

Background: RESET is a primary care workflow process that uses a reward-based, provider-controlled model to prioritize staff satisfaction in an attempt to improve primary care access, efficiency metrics, and patient satisfaction (Lutz, Fletcher & Hubbard, 2018). The term RESET represents the concepts of rewarding efficiency, setting priorities, and empowering teams. The program was originally developed at Ramstein Air Base in 2017 and the RESET operations manual was

2. Do you have intentions to publish and/or present the outcome/findings of this project?

- (●) YES
- ( ) NO

If YES, please indicate the forum in which you primarily plan to disseminate the information (e.g. local conference, international conference, peer-reviewed manuscript)

Findings will be reported during a Uniformed Services University of Health Sciences Research day. This project is a requirement for the degree: Doctorate of Nursing Practice.

3. Does the project include testing the safety and efficacy of a drug or device in a human subject?

- ( ) YES
- (●) NO

If YES, please explain:

4. Do you PRIMARILY intend the information you learn from this project to be generalizable beyond your institution?

Research is defined as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which are designed to contribute "generalizable knowledge" would be those whose original intent is to make public via oral presentation, poster, or journal publication outside of the Command at which the activity occurs, or outside of an Educational program (PhD program, for example) for which the activity was done.

◉ YES

○ NO

If Yes, please explain:

Information gleaned from this quality improvement project will be used to assist NH Bremerton and other MTFs in efforts to improve clinical workflow efficiency and increase family medicine staff reactions. The generalizable knowledge learned will be presented in both a podium and poster presentation during research week at the Uniformed Service University Graduate School of Nursing.

5. Do you PRIMARILY intend the information you learn to provide immediate and continuous improvement and feedback at your institution?

◉ YES

○ NO

If Yes, please explain:

We intend the findings to provide the institution immediate feedback regarding workflow efficiency and family medicine staff reactions following RESET implementation.

6. Are the activities or interventions considered standard of care?

- (●) YES
- ( ) NO

If Yes, please explain:

Activities measured are considered standards of care per The Joint Commission recommendations to ensure accessible services and care continuity under the PCMH model.

7. Are participants expected to benefit directly from these activities?

- ( ) YES
- (●) NO

If Yes, please explain:

8. Will you collect data from living individuals through some type of intervention?

- (●) YES
- ( ) NO

If Yes, please explain:

Mini-Z Burnout surveys will be given to family medicine staff using unique identifier codes at pre and post RESET implementation.

9. Will you interact in ANY way with a living individual?

- (●) YES
- ( ) NO

If Yes, please explain:

Protection of Human Subjects

All primary care staff will be uniquely identified for purposes of the Mini-Z burnout survey. The code to the unique identifiers will be stored in a locked cabinet in a secure space within NH Bremerton. Only DNP project students will have access to the cabinet key. The unique identifier code will be shredded after statistical analysis is completed at 5 months following RESET implementation. Personally Identifiable Information (PII) will not be used during any stages of the project.

10. Will you have access to individually identifiable information?

- ( ) YES
- (●) NO

If Yes, please explain:

11. Will you be utilizing the electronic medical record in any way?

- (●) YES
- ( ) NO

Please use this space to include any other information you would like considered in the determination of this review:

Project Lead and Department Head

The information provided clearly states the intention and plan for this project. All responsibilities and resources needed in conducting this project lies with the project lead and their respective department.

Project Lead

Signature and Date:

Department Head
Signature and Date:

CID DETERMINATION

(CID USE ONLY)

More information is required to complete review, specifically:

◉ **This is a Performance Improvement / Quality Assurance project.**

NOTES:

◯ **This appears to be a human subject research project and warrants full submission to the IRB**

NOTES:

Reviewer Signature and Date:

[redacted]

Data Sharing Agreement Form

[NAVAL MEDICAL CENTER/NMW COMMANDS] FY18

Data Sharing Agreement (DSA): Checklist to Determine Facility Level/Full DSA

Principal Investigator: Crystal Aandahl **CIP#:** NMCSD.QI.2019.0009

Study Title: A Reward Efficiency, Set Priorities, and Empower Teams (RESET)-Based Model

Date: (mm/dd/yyyy) 08/17/2018 **NMW Command:** NH Bremerton

Complete this form and digitally sign below. If you are NOT prompted to complete a full DSAA, you must send a copy of this checklist along with a copy of the protocol to Dr. Mitchell Dukovich at mitchell.dukovich.civ@mail.mil to determine if 1) your project is DSA exempt or 2) your project falls under our facility level DSA. If you ARE prompted to complete a full DSA application, please find the application here and submit application to DHA @ dha.datasharing@mail.mil.

Notes: Please add any additional notes on page 3 of this form.

Depending on your answers to other questions in this checklist, your study may: 1) be placed under the Facility Level DSA 2) require a Navy Medicine/DHA Level DSA Application OR 3) be DSA Exempt.

Protocol Information	Yes	No	If you answer NO to A, please provide description here:
A. Will the subjects for your project be limited to YOUR facility's (e.g. MTF) patients? (e.g. if you work at NMCSD, the project is limited to NMCSD patients). If you answer NO to this question, please provide a description of the population for your study and any research partners (e.g. all patient enterprise wide with a specific diagnosis).	☑	☐	
B. 1. Do you need data from your facility's (e.g. MTF) information systems (e.g. NMCSD's CHCS, AHLTA, Essentris,) for ANY reason for this project (identifying patients, reviewing medical records, etc.)?	☑	☐	If yes to B1, please explain the reason you need this data (i.e. to recruit, identify, collect data). – - Data collection from EHR to determine number of weekly virtual appointments completed by provider and care continuity of providers
2. Do you need data from M2/MHA that you can access locally for ANY reason for this project or that you will receive as an extract (identifying patients, reviewing medical records, etc.)?	☐	☑	If Yes to B2→ Stop and Complete full DSA Application
3. Is the data for your project collected directly from your facility's patients (person to person)?	☐	☑	If Yes to B3, your project is DSA Exempt. Send this checklist to Dr. Dukovich for a confirmation email.

Revised DSA Checklist 29MAR2018 1

[NAVAL MEDICAL CENTER/NMW COMMANDS] FY18

Protocol Information	YES	NO	NOTES
C. Will any data, that originated from your facility's information systems (CHCS, AHLTA, Essentris,) **including de-identified**, limited data set, personally identifiable information, or protected health information be transferred, stored, or accessed outside of the facility where the project is being conducted? **This also includes post study completion data sets sent to statisticians off site.	☐	☑	If Yes to C → Stop and complete full DSAA ans SSV
D. Will the project be conducted only by Active Duty, Civilian (GS) Personnel or Contractors that are considered part of the facility's workforce (Staff NMCSD)? Answer no if research partners are not staff at NMCSD, See below.	☑	☐	
F. Will there be research partners as part of an IAIR with NMCSD on-site or off-site involved?	☐	☑	If Yes to F list the IAIR number and research partners and organizations.
1) Is the research partner listed as an Associate Investigator (AI) on the IRB- approved protocol?	☐	☐	
2) Is under an IAIR?	☐	☐	
3) Is the AI the only research partner?	☐	☐	
Note 1 : Research partner should be an employee of a DoD facility with an IAIR with NMCSD. Other research partners from foundations, universities, organizations, or firms that are funded under a CRADA, grant, contract, or other arrangement to provide services to the facility are not included.			If Research Partners are not covered under F→ Stop and Complete full DSA Application

Do you need a full DSA?

YES → Send this form to Dr. Dukovich, upload with your EIRB package (so the IRB administrators are aware that you in the process of completing a full DSAA) When complete forward the full DSAA to Dr. Dukovich with all documentation and SSV if needed.

NO → Send this form and a copy of your protocol to Dr. Dukovich for review ; upload reviewed and signed Check List to your protocol file.

Please electronically sign below (or manually sign if e-signature is not possible). ***DSA Checklist reviewer signature confirms that project falls under FLDSA. This document will not be signed by a reviewer if a full DSA is required.***

[redacted]

Signature of Principal Investigator **Signature of DSA Checklist Reviewer**

Revised DSA Checklist 5 Jun 2018 2

Command Approval Form

30 Nov 2018

From: Phase II Site Director, USUHS
To: Commanding Officer, Naval Hospital Bremerton
Via: Executive Officer, Naval Hospital Bremerton

Subj: PERMISSION TO CONDUCT EVIDENCE-BASED PROJECT

Encl: (1) Project Package with NMCSD CID Approval Number NMCSD.QI.2019.0009

1. Respectfully request permission for the Family Nurse Practitioner (FNP) Doctor of Nursing Practice (DNP) students assigned to Naval Hospital Bremerton (NHB) to conduct an evidence-based project in fulfilment of their DNP degree. The leadership in the Family Medicine Clinic are included in the development of the project. The Phase II Site Director will serve as the Principle Investigator for the project.

2. Enclosure (1) contain the details of the project approved by Naval Medical Center San Diego (NMCSD) Clinical Investigations Department (CID) as a quality/process improvement project.

3. The students are required to present the findings of their project to leadership at NHB and USUHS. Any submissions for professional presentations or publications will be submitted to NMCSD CID for approval by the Medical Editor and to the NHB Commanding Officer and Public Affairs Officer.

[redacted]

A. I. SAVAGE

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11 Dec 18

FIRST ENDORSEMENT

From: Commanding Officer, Naval Hospital Bremerton
To: Phase II Site Director, USUHS

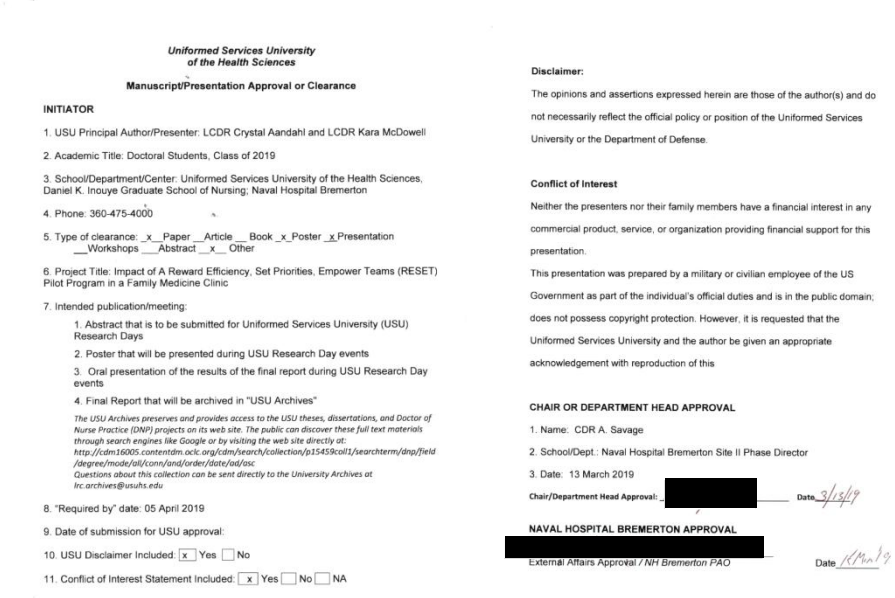
1. I approve the collection of data by the USUHS FNP DNP students for the evidence-based project with NMCSD CID approval number NMCSD.QI 2019.0009.

2. Any changes will be routed for approval.

3. My point of contact is CDR Michael J. Grande, who may be reached at COMM: (360) 475-4210, DNS: 494-4210, or e-mail: Michael.j.grande2.mil@mail.mil.

[redacted]

Appendix F
PAO Clearance for archiving final report to "*USU Archives*"



Uniformed Services University of the Health Sciences

Manuscript/Presentation Approval or Clearance

INITIATOR

1. USU Principal Author/Presenter: LCDR Crystal Aandahl and LCDR Kara McDowell

2. Academic Title: Doctoral Students, Class of 2019

3. School/Department/Center: Uniformed Services University of the Health Sciences, Daniel K. Inouye Graduate School of Nursing; Naval Hospital Bremerton

4. Phone: 360-475-4000

5. Type of clearance: _x__Paper __Article __ Book _x_Poster _x_Presentation __Workshops ___Abstract __x__ Other

6. Project Title: Impact of A Reward Efficiency, Set Priorities, Empower Teams (RESET) Pilot Program in a Family Medicine Clinic

7. Intended publication/meeting:

1. Abstract that is to be submitted for Uniformed Services University (USU) Research Days

2. Poster that will be presented during USU Research Day events

3. Oral presentation of the results of the final report during USU Research Day events

4. Final Report that will be archived in "USU Archives"

The USU Archives preserves and provides access to the USU theses, dissertations, and Doctor of Nurse Practice (DNP) projects on its web site. The public can discover these full text materials through search engines like Google or by visiting the web site directly at: http://cdm16005.contentdm.oclc.org/cdm/search/collection/p15459coll1/searchterm/dnp/field/degree/mode/all/conn/and/order/date/ad/asc
Questions about this collection can be sent directly to the University Archives at lrc.archives@usuhs.edu

8. "Required by" date: 05 April 2019

9. Date of submission for USU approval:

10. USU Disclaimer Included: [x] Yes [ ] No

11. Conflict of Interest Statement Included: [x] Yes [ ] No [ ] NA

Disclaimer:

The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.

Conflict of Interest

Neither the presenters nor their family members have a financial interest in any commercial product, service, or organization providing financial support for this presentation.

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CHAIR OR DEPARTMENT HEAD APPROVAL

1. Name: CDR A. Savage

2. School/Dept.: Naval Hospital Bremerton Site II Phase Director

3. Date: 13 March 2019

Chair/Department Head Approval: [redacted] **Date** 3/15/19

NAVAL HOSPITAL BREMERTON APPROVAL

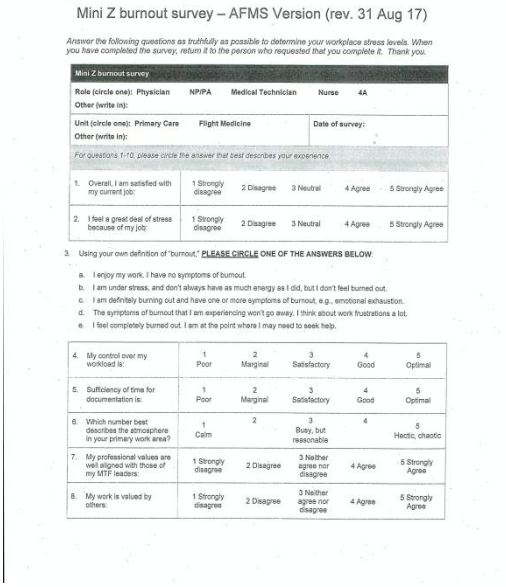
[redacted]

External Affairs Approval / *NH Bremerton PAO* Date 15 Mar 19

***Note:** It is DoD policy that clearance of information or material shall be granted if classified areas are not jeopardized, and the author accurately portrays official policy, even if the author takes issue with that policy. Material officially representing the view or position of the University, DoD, or the Government is subject to editing or modification by the appropriate approving authority.

Appendix G

All forms (blank forms) used in data collection



Mini Z burnout survey – AFMS Version (rev. 31 Aug 17)

Answer the following questions as truthfully as possible to determine your workplace stress levels. When you have completed the survey, return it to the person who requested that you complete it. Thank you.

Mini Z burnout survey

Role (circle one): Physician NP/PA Medical Technician Nurse 4A **Other (write in):**	
Unit (circle one): Primary Care Flight Medicine **Other (write in):**	**Date of survey:**

For questions 1-10, please circle the answer that best describes your experience.

1. Overall, I am satisfied with my current job:	1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
2. I feel a great deal of stress because of my job:	1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree

3. Using your own definition of "burnout," **PLEASE CIRCLE ONE OF THE ANSWERS BELOW:**

a. I enjoy my work. I have no symptoms of burnout.
b. I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
c. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.
d. The symptoms of burnout that I am experiencing won't go away. I think about work frustrations a lot.
e. I feel completely burned out. I am at the point where I may need to seek help.

4. My control over my workload is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal
5. Sufficiency of time for documentation is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal
6. Which number best describes the atmosphere in your primary work area?	1 Calm	2	3 Busy, but reasonable	4	5 Hectic, chaotic
7. My professional values are well aligned with those of my MTF leaders:	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
8. My work is valued by others:	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree

9. My unit has successfully completed projects that improve work processes	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
10. The degree to which my care team works efficiently together is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal
11. The amount of time I spend on the electronic health record (EHR) at home is:	1 Excessive	2 Moderately High	3 Satisfactory	4 Modest	5 Minimal/None
12. My proficiency with EHR use is:	1 Poor	2 Marginal	3 Satisfactory	4 Good	5 Optimal
13. I am frustrated with our current EHR:	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
14. My team is adequately manned for our mission:	1 Strongly disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
15. How many hours do you work in a typical week?	_____ HOURS				

16. Tell us more about your stresses and what we can do to minimize them (optional):

Demographic Questions

For the following, please choose the answer that best describes you.

Rank: _____

Gender: __ Female __ Male

**Questions drawn mainly from the Physician Worklife Study, MEMO study, and Healthy Workplace Study. The Mini Z was developed by Dr. Mark Linzer and team at Hennepin County Medical Center, Minneapolis. For more information please contact mark.linzer@hcmed.org.*

Thank you for taking the Mini Z survey.

Questions may be directed to:
Col John Oh, 703-681-7629 (DSN 761), john.y.oh.mil@mail.mil

Appendix H

DNP Project Completion Verification Form

Appendix G: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled: **Impact of A Reward Efficiency, Set Priorities, Empower Teams (RESET) Pilot Program in a Family Medicine Clinic** was completed at Naval Hospital Bremerton by the following student(s):

(type student name)	*(signature)*	*(date)*
Crystal Aandahl	[redacted]	9APRIL2019
Kara McDowell		9 April 2019

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

(type name)	*(signature)*	*(date)*	
[redacted]		5APR2019	Senior Mentor
			Team Mentor
			Team Mentor
Assanatu I. Savage	[redacted]	11APR2019	Team Mentor & Phase II Site Director

For RNA Students only - add the following additional signature for final verification of project completion:

RNA Project Director *(type name)*	*(Signature)*	*(Date)*

Form Version: 26 Aug 2017