

TOWNER- SCHAFER REPORT

2025
EDITION

INSIGHTS FROM
SOME
INFLUENTIAL
PHYSICIAN
ASSISTANTS





Towner-Schafer Report

*The Official Newsletter of
the Society of Air Force Physician Assistants*

2025 Edition

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REVIEW AFPARC 2024 IN

MAJOR ERIN SCHMITZ
PAST DIRECTOR OF
ACTIVITIES



IT HAS BEEN MY PLEASURE TO HELP PLAN THE LAST THREE PA READINESS COURSES SINCE OUR RETURN TO IN PERSON EVENTS FOLLOWING THE PANDEMIC. I HAVE MET SO MANY OF YOU, LEARNED SO MUCH ABOUT EVENT PLANNING, READINESS AND MYSELF. MY GOAL EVERY YEAR HAS BEEN TO IMPROVE AT LEAST ONE THING AND I THINK I'VE DONE THAT BUT I'VE ALSO COME TO REALIZE THIS IS AN EVER-EVOLVING COURSE.

AT THE CORE IS READINESS BUT THE IMPORTANCE OF MENTORSHIP, NETWORKING AND SKILLS UPDATES CANNOT BE OVERSTATED. THIS YEAR WE WERE SUCCESSFUL IN BRINGING IN NEW EXHIBITORS INCLUDING THE STATE DEPARTMENT AND LYNCHBURG UNIVERSITY. WE ALSO HAD OUR FIRST EVER LECTURE FROM AAPA PRESIDENT FOLUSHO OGUNFIDITIMI AND CME4LIFE OWNER AND CEO JOHN BIELINSKI! WE HAD A RECORD NUMBER OF ATTENDEES; 279 INCLUDING 70 GUARD AND RESERVE. THAT BEING SAID, A LOT OF YOU FELT THE SQUEEZE AS WE TRIED TO FIND ENOUGH SPACE IN OUR BELOVED DRURY PLAZA BALLROOM. ADDITIONALLY, MANY OF YOU EXPRESSED FRUSTRATION WITH PARTS OF THE REGISTRATION PROCESS AND THE WORKSHOPS AVAILABLE. I HEAR YOU LOUD AND CLEAR; MORE SPACE, MORE WORKSHOPS AND BETTER COMMUNICATION ABOUT THE REGISTRATION PROCESS ARE AT THE TOP OF MY PLANS FOR 2025.

AS CAPT AYALA SAID AT THE END OF THIS YEAR'S AFPARC, EACH OF YOU THAT ATTENDED ARE NOW THE SUBJECT MATTER EXPERTS AT YOUR BASE. I ASK EACH OF YOU TO TAKE THAT ON, HELP ANOTHER PA FIGURE OUT HOW TO REQUEST UNIT FUNDING, MAKE SURE YOU'RE BOTH ON THE CONSULTANT'S EMAIL LIST OR IF YOU'RE LOCAL TO SAN ANTONIO GET INVOLVED AS A VOLUNTEER. IN THE COMING MONTHS, EXPECT TO HEAR MORE FROM YOUR AFPARC PLANNING COMMITTEE TO INCLUDE DATES, VENUE, LODGING, AGENDA AND A FEW REQUESTS. HERE'S TO BECOMING THE READINESS CHAMPIONS OF THE AFMS!

MAJOR ERIN SCHMITZ

SAVE THE DATE!

AIR FORCE PA READINESS COURSE (AFPARC)

April 14-18, 2025

REGISTRATION COMING SOON
New Location: Gunter Hotel

The central funding list is being finalized and will be distributed soon to ensure eligible attendees can begin planning their participation.



CONSULTANT'S CORNER

COLONEL JACQUELINE BGVALARI

As medical providers, we constantly help others, be it our patients, spouses, children, furbabies, aging parents, extended family, and friends. What happens when we need assistance? Air Force Personnel Center (AFPC) offers a few programs to help.

- The Humanitarian Reassignment and Deferment Program
- High School Seniors Assignment Deferment
- Court-Ordered Child Custody Program (CCCP)

The first is the Humanitarian Reassignment and Deferment Program. The goal of this program is to help active-duty Airmen resolve severe, short-term problems involving a family member. Members can apply for a one-time reassignment or deferment if a critical problem occurs, normally within 12 months. The definition of 'family member' is limited to spouse, child, parents, to include in-laws and stepparents, person in loco parentis, or other persons residing in the household, who are dependent on the Airman for more than half of their financial support. When a request involves reassignment, it will normally be to the closest base to the concerned family member. The Air Force cannot make moves at government expense based solely on humanitarian reasons. The reassignment or deferment must still meet Air Force mission needs, in addition to helping the Airman. Therefore, a valid vacancy must exist at the gaining base and the Airman must meet retainability requirements for a permanent change of station (PCS).

The second program is the High School Senior Assignment Deferment (HSSAD). The HSSAD is designed to decrease turbulence and increase stability for military families with dependent children entering their senior year of high school. Members who meet eligibility requirements can defer an assignment for up to one year. HSSAD requests are considered on a case-by-case basis with the goal of approving as many requests as possible while meeting mission needs. Members must provide a memorandum from the dependent's high school counselor confirming the dependent's current school grade and projected senior year graduation date. The Military Personnel Flight (MPF) must verify the dependent child is enrolled in Defense Enrollment Eligibility Reporting System (DEERS) and lives with the member requesting the deferment.

The last is the Court-Ordered Child Custody Program (CCCP). This program was established on 28 Jul 2020 and intended to increase military family stability. To be eligible for enrollment into the CCCP, service members must provide required documentation, request enrollment into the program, be named a custodial parent in a finalized court-ordered child custody decree, and have that child or children enrolled in DEERS. There are two options within this program, either the Court-Ordered Child Custody Assignment (CCCA) or the Court-Ordered Child Custody Deferment (CCCD). Members will submit their CCCA/CCCD application and required documents through their Commander's Support Staff (CSS).

For more information, please refer to DAFI 36-2110, Total Force Assignment, dated 9 August 2024.

PAAs in Action



**A NEW
LOOK!**

Website Integration

The SAFPA Communications Department has been hard at work developing the new website for our great organization. After 1 year website trials, hurdles, and challenges, the new website is fully working.

Part of the integration included building a new website from scratch through different platforms. The communications department had to learn new skills in web design and are still learning more.

On the new website, anything you need should be accessible. You can see your membership information, updates on events, AFPARC information, and valuable news from the guard and reserve.

If you notice anything that needs to be changed or if you have any questions, please email safpabod@gmail.com and we will get back to you as quickly as possible.

Enjoy,

SAFPA Communications Department

Understanding Provider Burnout Globally: Exploring its correlation with Depression and Mitigation Strategies

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Title

Understanding Provider Burnout Globally: Exploring its Correlation with Depression and Mitigation Strategies

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Conflict of Interest

I have no conflicts of interest to disclose. I certify that I am the sole author of this review article.

Keywords

Clinician burnout, burnout and depression, burnout mitigation, depression treatment.

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Abstract

With the recent pandemic fresh in everyone's minds, the issue of clinician burnout continues to worsen globally. Burnout is not new, but when the pandemic hit, clinicians and other medical workers were forced to push themselves to the breaking point to keep up with the healthcare demand. However, the problem with burnout persists at a higher level even though the pandemic has ended. Across the globe, the levels of clinician burnout are climbing, and with it, more and more clinicians are also developing depression symptoms. What are the correlations between burnout and depression symptoms among clinicians in various specialties across the world? With burnout, many clinicians also suffer from depression and/or anxiety as emotional exhaustion and work stress push good clinicians to their breaking points. While plenty of research has explored burnout, depression, and treatment or mitigation techniques, none has wrapped it all into one article.

Introduction

Clinician burnout has become an important topic over the last few years. New research from the Centers for Disease Control and Prevention indicates that levels of fatigue and burnout in healthcare workers have reached crisis levels (1). Research has shown burnout among primary care staff in Iran at 52.9%, and 79.1% of physicians working at a tertiary hospital in West India reported moderate to high levels of emotional exhaustion, one of the three components of burnout from the Maslach Burnout Inventory (2,3). During the COVID-19 pandemic, levels of burnout continued to rise, with one meta-analysis noting an average of 52% of healthcare workers reporting burnout, and data show a gradient increase of burnout from high to lower-income countries (4). Additionally, burnout levels also affect the next generation of clinicians, with research showing almost 80% of PA students at one program reporting high levels of emotional exhaustion (5). Additionally, another study demonstrated that medical students in general surgery, anesthesiology, obstetrics/gynecology, and orthopedics reported almost 41% burnout prevalence, with an overall burnout prevalence of 35.7% across all specialties (6).

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“Awareness of physician burnout in the United States has increased dramatically. There have been 10 times as many published scholarly articles [in 2022] on burnout as 20 years ago, and the National Academy of Medicine and the U.S. Surgeon General’s office have recently published reports on clinician burnout.”(7) Studies have estimated more than 50% burnout rates among US physicians, with even higher rates estimated among primary care physicians (8). PAs in some specialties, such as oncology, emergency medicine, and family medicine, have shown levels of burnout higher than 60% (9). Studies have also linked burnout to an increased prevalence of depression, anxiety, alcoholism, substance abuse, and suicidal ideation (10). The literature supports growing levels of depression in clinicians experiencing high levels of burnout globally. This is why finding evidence-based strategies for the treatment of depression and burnout is needed now more than ever. The purpose of this paper is to bring together the data that demonstrate the correlations between burnout and depression in clinicians with evidence-based mitigation techniques for burnout and treatment for depression.

Methods

A search of the bibliographic databases PubMed, EBSCO Discovery Service, and Medline Ultimate was completed using a combination of free-text and medical subject heading (MeSH) search terms with keyword searches of “clinician burnout,” “correlation of burnout and depression,” “treatment of depression,” and “mitigation of burnout” with inclusive dates from January 2018 to present. A total of 741 articles were published on clinician burnout, 74 articles were published on the correlation between burnout and depression, 3,242 articles were published on the treatment of depression, and 371 articles were published on the mitigation of burnout. Of the total 4,354 articles from the results, 4,126 were excluded due to duplicates, titles too distant from the research themes, and cursory review of the articles. Inclusion criteria were articles researching physicians, PAs, and nurse practitioners, including students of any of these three types of clinicians. These results were further reduced by exclusion criteria of articles that included data for healthcare workers not considered clinicians (e.g., nurses, technicians, laboratory personnel, etc.) After applying these criteria, 30 articles were selected that demonstrated levels of clinician burnout, the correlation of burnout with depression, and treatment/mitigation techniques for depression and burnout.

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Results and Discussion

Provider Burnout and Depression

Burnout alone has prompted the CDC to call it at a crisis level, but of those providers with burnout, many are also developing depressive symptoms. In most studies involving burnout, the Maslach Burnout Inventory is used to estimate burnout by measuring increased Emotional Exhaustion (EE), increased Depersonalization (DP), and decreased feelings of Personal Accomplishment (PA) (11). The study *Depression and Burnout Symptoms Among Air Force Family Medicine Providers* highlighted that an astounding 84% of participants with burnout scored positive for degrees of depression symptoms (12). The inherently high-stress environment of military settings, both at home stations and deployed, may add another factor to explain this extremely high percentage, but primary care has continued to be among the specialties with the highest levels of burnout (8,13). This study surveyed 726 active duty Air Force family medicine providers (387 physicians, 278 PAs, and 61 NPs) aged 20 to 60, with 150 responses (12). Figure 1 highlights the distribution of depression from PHQ-9 scores. Figure 2 highlights the distribution of burnout among the providers who scored low, medium, and high on the PHQ-9.¹² The PHQ-9 is scored in a range of 0 to 27, with a score of 0 being no depression, a score between 1 and 4 being minimal, a score between 5 and 9 being mild, a score between 10 and 14 being moderate, a score between 15 and 19 being moderately severe. A score between 20 and 27 being severe.¹⁴ The authors then broke these scores down into low (scores 0-14), medium (scores 15-24), and high (scores >25) (12). They discovered that 126 out of the 150 respondents scored positive for some degree of depression symptoms had strong correlation with both EE and DP, but surprisingly, 95% of the respondents had at least medium or high levels of PA with practicing primary care medicine (12).

Another study, *Depression, Burnout, and Professional Outcomes Among PAs*, demonstrated a burnout prevalence in the range of 64% to 80% among PAs across the US (9). Additionally, the study highlighted the strong association between burnout, depression, and adverse practice outcomes (9).

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As with the previous study, this one identified high levels of PA (53%) among the participants, but 45.9% reported EE, 30.2% reported DP, and 34.3% reported overall burnout.⁹ Regarding mental health, 6.1% of those with burnout reported moderate to severe depression, 12.6% reported moderate to severe anxiety, and 80% reported at least one medical error (9).

The perspective article from the New England Journal of Medicine *Is It Burnout or Depression* noted that growing attention to burnout in the US has highlighted that “health care systems, rather than the individual,” is the primary driver of the problem (7). However, there are still stigmas that equate “burnout to depression shifts the responsibility from the workplace to the individual.”(7) Furthermore, the author notes that EE has a stronger correlation with depressive symptoms than DP and PA because work-related stress, a vital component of EE, is the primary driver of depression among providers (7). The increased work stress that comes along with practicing medicine dramatically contributes to increased rates of depression. Medical student depression prevalence is similar to that among young adults, but depression rates quintuple immediately after residency begins (7). This further supports that rates of depression among providers are greatly affected by the conditions of practicing medicine, not individual factors (7). This means that burnout and mental illness in providers are both related to work stress from practicing medicine. Therefore, the stigma of personal weakness is inappropriate for providers suffering from depression due to burnout.

Mitigation Strategies for Burnout

The approaches to mitigating burnout involve a few options, including technological advancements, institutional changes, and personal strategies. Emotional exhaustion from work stress must be a critical focus since it has the most significant effect on burnout and depression. Given the prevalent issue of burnout leading to medical errors, inefficient use of health information technologies (HIT) is attributed to having a role in burnout (9,15).

The literature review *A Scoping Review of Health Information Technology in Clinician Burnout* first sought to identify HIT trends in burnout studies over time and then examine the evidence to synthesize the themes of HIT’s roles in burnout to identify mitigation opportunities (15).

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Not surprisingly, the electronic health record (EHR) systems were the most common focus of the studies included in this literature review, but the studies also demonstrated that HIT can intervene and mitigate burnout levels (15). The results indicated clinicians who reported spending more time working on their EHR systems after hours were more likely to report burnout and feeling like the amount of time needed to record notes in the EHR led to higher levels of EE and, subsequently, higher levels of burnout (15). Options to allow HIT to help mitigate burnout are using mindfulness training apps, in-depth EHR-focused training, education to help providers use the EHR more effectively to save time, and standardizing and formatting the alerts in the EHR (15). Additionally, other digital tools can save or optimize a provider's time, and applying quality improvement to workflows can help mitigate burnout (16). Furthermore, quality improvement strategies to optimize training, team expansion, and how providers spend their time can further reduce provider burnout (16).

Another approach is related to changes in how the healthcare systems help the providers to deal with the factors of burnout that lead to depression symptoms (17). The data show symptoms of depression occur half as often when healthcare workers are allowed to take part in workplace decisions (1). Employers that build trust and increase supervisory support by allowing providers to participate in decision-making, empowering supervisors to support improved work-life balance, monitoring staffing needs and incidents of harassment, and designing policies to help workers feel safe that their mental health is protected (1). Another report noted the current methods of measuring health care quality are not meeting the strategic objectives (18). Less than half of the endorsed metrics demonstrate clinical validity, provider merit-based incentive payment systems (MIPS) scores are inconsistently correlated with patient outcomes, and the Hospital Readmissions Reduction Program is paradoxically associated with increased 30-day post-discharge mortality after hospitalization for heart failure (18). The Centers for Medicare & Medicaid Services officials admit that metric proliferation has caused “confusion, increased reporting burden, and misalignment of approaches for common clinical scenarios” that has added an increased burden on providers already suffering from work stress and EE (18).

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Therefore, reforming the system that dictates the health care quality metrics will hopefully reduce the sky-high administrative costs and burnout levels (18). A small study of 28 clinicians who worked in a Federally Qualified Health Center (FQHC) reviewed the findings of a focus group after these clinicians participated in a year-long wellness initiative identified five key themes that could be changed to reduce burnout: (1) clinician workload burden and feeling personally responsible when their workload kept them from providing optimal care to patients; (2) systemic problems exacerbated burnout; (3) support staff like medical assistants, scribes, schedulers, and front desk personnel play a critical role in the wellness of the entire team; (4) perceived differences in priorities between administration and providers contributes to burnout; and (5) clinicians could effectively care for patients if they had a communicative and stable team surrounding them (13). Applying the multifaceted lessons learned from this study at healthcare systems can help to mitigate burnout (13).

Finally, provider-focused wellness activities can also help reduce burnout levels. A study identified five general categories designed to foster wellness and reduce burnout, depression, and suicide risk among providers: breathing exercises, meditation, web-based Cognitive Behavioral Therapy, and suicide prevention apps (19). This is a starting point to enhance coping with work stressors. However, other studies also focused on wellness techniques to help mitigate burnout. Practicing mindfulness-based interventions is the most common personal mitigation technique to combat burnout (17,20–23). A systemic review of articles “suggests that future wellness initiatives should focus on grounding interventions in educational theory, forging consensus on wellness instruments with validity evidence, and examining the impact of these initiatives on patient outcomes.”(21) Regular participation in stress management programs and facilitated discussion groups have shown promising results in reducing burnout (21). Moreover, starting in the various provider schools, wellness interventions should be linked to educational theories on narrative medicine, risk and protective factor model, stress recognition, mental health, visual thinking strategies, and humanistic care, which can all help new providers learn and hone these skills at the same time as they are honing their medical knowledge (21). Professional schools of medicine can implement these mindfulness interventions more readily than the healthcare systems overwhelmed with patients. Therefore, future providers will enter the workforce armed with several techniques to help them mitigate burnout.

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Given this information, the next logical question becomes, “Which mitigation technique is the most effective?” This question doesn’t have a definitive answer because different techniques work better for different people, but the article *Job Burnout Mitigation: A Comprehensive Review of Contemporary Strategies and Interventions* provided the true answer to this question; “Addressing job burnout requires a multi-faceted approach, integrating individual, organizational, technological, and policy-driven interventions.”(24) For many providers, individual-level mitigation strategies represent the most effective option because they allow anonymity while effectively reducing stress and burnout. However, if the medical community continues to approach this issue with the current catch-22 attitude that compels providers to raise their hands if they are having problems but then punishes them when they aren’t meeting metrics due to reducing workloads, we will never achieve lasting results. What we need is a holistic approach that includes: (1) individual strategies such as stress management training, mindfulness programs, counseling and psychological support, resilience training, physical wellness programs, and skills development workshops; organizational strategies such as workload adjustments, role clarification, improving work-life balance, fostering a supportive work environment, employee development and career growth opportunities, and recognition and reward systems; technological strategies such as AI for workload management, improved HER systems, teletherapy and online counseling services, wearable stress-management devices, VR relaxation and training options, and employee engagement platforms; and policy-driven mitigation strategies such as industry standards for workplace well-being, mental health days, and quality metrics that support not only the patients but also the clinicians (24).

Treatments for Depression

There are many years of evidence-based depression treatments available to focus on the treatment of providers. The treatment options are the same for providers as they are for any other patient, but there is one factor that must be considered: the willingness of the provider to admit to having depression (7). Many providers fear that admitting to symptoms of mental health problems can get them pulled from patient care and potentially affect their ability to provide for their families (7).

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Additionally, providers who do admit to depression may have a reduction in their empanelment and number of appointments, which can add further burden on their fellow providers and thereby increase the likelihood of other providers suffering from burnout and depression symptoms (7).

The health care system must embrace patient safety while protecting its providers by allowing them to receive treatment without too much impacting their finances and fellow providers. Temporary staff, such as travel providers, can be hired to cover patient treatment while the primary care provider receives treatment. The American Psychological Association Clinical Practice Guideline (CPG) for the treatment of depression highlights that treatment should be individualized to help identify factors that might require modifications to a treatment recommended by the CPG (25). However, the standard options for the treatment of depression continue to be the mainstay whether the patient is a provider or a school teacher. For initial treatment of adult patients with depression, the panel recommends starting with either psychotherapy or a second-generation antidepressant (25). Effectiveness of psychotherapy is similar across behavioral therapy, cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPP), psychodynamic therapy, and supportive therapy, so any of these options is a good choice depending on the individual being treated (25). Next, the panel recommends consideration of combination treatment with both CBT or IPP and a second-generation antidepressant (25). Further, complementary and alternative treatments such as exercise therapy, yoga, St. John's Wort, bright light therapy, Tai Chi, acupuncture, or omega-3 fatty acids should also be considered (25,26). If the patient continues to have breakthrough symptoms, another antidepressant medication can be added, or the initial medication can be switched to a different class, such as an SNRI (25). For treatment-resistant depression, consider adding an atypical antipsychotic (26,27). The key is crafting a treatment plan that is individualized to the patient to focus on what works best for them (25).

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Conclusion

Provider burnout has reached critical levels, and the literature supports a growing number of providers who are experiencing depression and other mental health issues due to burnout (1,9,12,28). The COVID-19 pandemic added a new level to the rates of burnout, and even students have higher burnout levels (4,5,10,21,29). The data show most specialties are experiencing high levels of burnout and depression, but specialties such as surgery, primary care, oncology, OB/GYN, and the ER are the highest (2,3,7,9,12,30,31). All the research points to the need to focus on mitigating burnout, treating depression, and improving our healthcare systems to help turn the tide (1,5,13,15–23,25,26). The healthcare systems, medical, PA, and NP schools must implement mindfulness strategies for their workers and students to help them learn strategies to combat burnout and depression. Additionally, improving our EHRs, HIT, and quality care metrics will help reduce the burden on our providers, reducing work stress, EE, and depression symptoms. Finally, we need to allow our providers time and job safety so they will feel encouraged to get the treatments they need to reduce their symptoms of depression. When addressing a medical emergency, the first rule is to ensure the environment/scene is safe so new casualties are not added when providers run into an unsafe situation. The problem of burnout and depression in providers must be approached in the same way; we need to ensure our providers are safe and protected, or we will inherently add more casualties with medical errors and poor care for patients. Only working together will allow these critical changes to be made.

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Automatic renewal (recurring payments)
Choose this if you prefer to pay year to
year for your SAFPA membership. Thank
you for signing up!

SAFPA 5-Year Membership - \$145.00

Subscription period: 5 years
No automatically recurring payments
Choose this option if you prefer to pay
only every 5 years for your SAFPA
Membership.

42G LtCol Selectees 2025

WELCOME THE NEW LTCOLS

A very special
shout out to our
past president
Lt Col Select
Emily De Leon



CONGRATULATIONS

Thank you for being committed to your country and your profession! We are one of thirteen specialties within the biomedical service corps which makes this selection incredibly competitive.

Congratulations again to a well deserving group.

SAFPA BOARD OF DIRECTORS

Officers **Directors at Large**

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- Chief Delegate: Maren Smith
- Delegate: Haley Emery

**Thank you
to all our
outgoing
Board of
Directors
members!**

**IF YOU HAVE ANY RECOMMENDATIONS ON ARTICLES, OR ANY OTHER QUESTIONS
OR IDEAS TO MAKE YOUR TSR BETTER, PLEASE REACH OUT**

SAFPABOD@gmail.com

PAS GO BEYOND

