flpps Finger Lakes Performing Provider System

Common Ground Health

Regional Consortium on Health Care Workforce

October 30, 2025

Welcome!

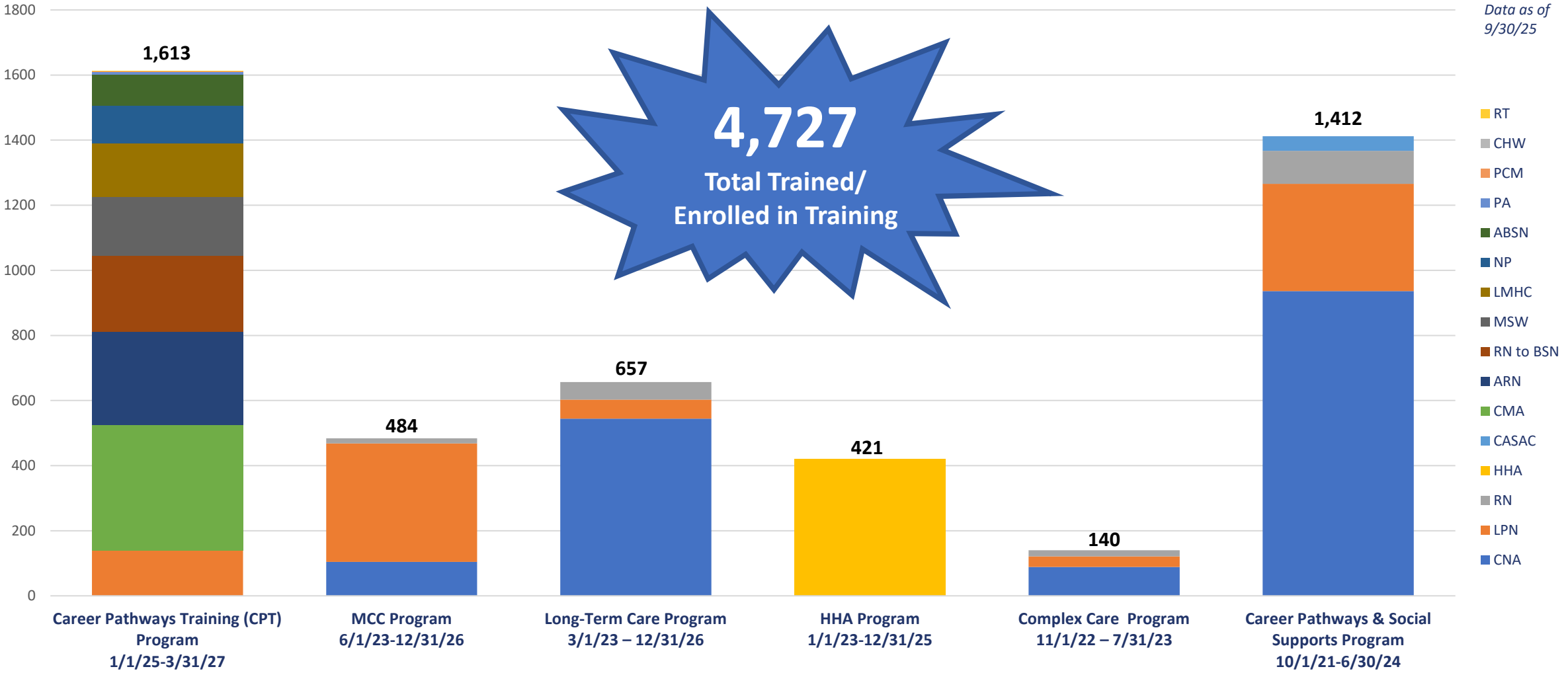
- Please include your name and organization in your Zoom screen and introduce yourself in the chat.
- This meeting is being recorded. We love to see you please keep your camera on. ☺
- Please mute yourself unless speaking.
- To share feedback or ask questions, please use the “raise hand” feature and we will call on you to speak.
- We are reserving the chat for questions, and will call on participants to speak to their questions entered in the chat.

Agenda

- WIO Update: Workforce Programs
  - Carol Tegas, CEO, Finger Lakes Performing Provider System
- Attracting & Retaining a Workforce: Lessons Learned
  - Jill Knittel, President & CEO, JK Executive Strategies
- Workplace Violence and Clinician Burnout: Impact, Causes, Interventions.
  - Michael Privitera, MD, MS, Professor Emeritus – University of Rochester Medical Center

Carol Tegas,
CEO, FLPPS

FLPPS WIO Workforce Programs



Jill Knittel,
President & CEO, JK Executive Strategies

Attracting & Retaining a Workforce: Lessons Learned

Today's Focus

- Current healthcare workforce trends
- The Gen Z and COVID effect
- Elements of a healthy work environment
- Engagement & Retention Best Practices
- How leaders build strong cultures

Healthcare Workforce Snapshot (‘24-’25)

Turnover Statistics:

- **Mental Health Clinicians: 33%**
- **Home Health Aids: 36%**
- **RN’s: 16.4%**
- **Overall hospital turnover: ~18%**
- **Front-line home care workers: 75-79% with many leaving within 100 days**

- **US Hospitals added 304,000 individuals (~5.4% growth) including ~98,000 RNs in 2024**
- **Mental Health jobs are projected to grow 3x faster than all US Occupations in the next decade with approximately 84,000 jobs added**

Healthy Work Environment

- ✓ Psychological safety
- ✓ Flexibility & autonomy
- ✓ Mental health & wellness support
- ✓ DEI and belonging
- ✓ Opportunities for growth

The Gen Z & COVID Shift

Before (Pre-Gen Z & Pre-COVID)	**Now** (Gen Z + Post-COVID)
Rigid schedules	Flexibility, autonomy
Top-down communication	Transparent, inclusive leadership
Clinical burnout normalized	Mental health prioritized
One-size-fits-all benefits	Personalized well-being and DEI focus
Experience = loyalty	Culture + values = retention

Employee Engagement Best Practices

- Pulse surveys + follow-up action
- Transparent leadership communication
- Peer and manager recognition
- Career development programs
- Internal mobility and upskilling

Leadership Drives Culture

- Build resilient teams
- Lead with empathy and clarity
- Support middle managers
- Model adaptability and purpose
- Make space for innovation and wellness

Data-Driven Engagement

- Use predictive analytics to flag risk
- Monitor 1st-year turnover closely
- Personalize recognition and rewards
- Track progress—not just performance

RochesterWorks

Job Quality Assessment Survey

- Confidential, free self-assessment tool provides Rochester companies with the data they need to identify challenges and make positive changes in the work environment.
- Built to benchmark not just with industry peers, but with specific occupational titles
- Enough participation within an industry allows for confidential benchmarking relative to job quality for a specific occupational title

Who should take the survey?

1. Employers struggling to attract and retain talent
2. Employers who want to create the best possible employee experience

Learn More:

Tinyurl.com/JQAInfoSession

Take Survey:

www.ROCJobQuality.com

BizServices@rochesterworks.org

Tech & Talent: Partners, Not Opposites

- AI reduces admin load—frees up care time
- 40% of workforce needs AI reskilling
- Staff must be included in AI planning
- Transparency = Trust in tech

The Retention Recipe

- Purpose > Pay
- Well-being > Workload
- Flexibility > Rigidity
- Growth > Plateau
- Belonging > Benefits

Final Thoughts

- 🏆 Hire for culture + adaptability
- 📈 Invest early in leadership development
- 🧠 Watch for early warning signs
- 🔁 Build systems for internal mobility
- 👏 Tailor recognition to role

Discussion & Questions

Michael Privitera, MD, MS
Professor Emeritus,
University of Rochester Medical Center

Workplace Violence and Clinician Burnout:

Impact, Causes, Interventions.

Michael R Privitera MD, MS
Professor Emeritus URMC
University of Rochester Medical Center
Medical Director, Medical Faculty and Clinician Wellness Program, 2015-2022
Chair, MSSNY Task Force on Physician Stress and Burnout, 2015-2019
Faculty, Institute for Healthcare Improvement. Boston MA, 2022-present

Healthcare Workforce Consortium
10-30-25

What is Workplace Violence?

1. **Any physical assault, threatening behavior, or verbal abuse occurring in the workplace.**

2. **Includes but is not limited to beatings, shootings, rape, suicide or attempts**

3. **P*sychological traumas, such as threats to harm, obscene phone calls, intimidation, bullying, incivility, harassment, including being followed or sworn at.***

National Institute for Occupational Safety and Health Administration (NIOSH)

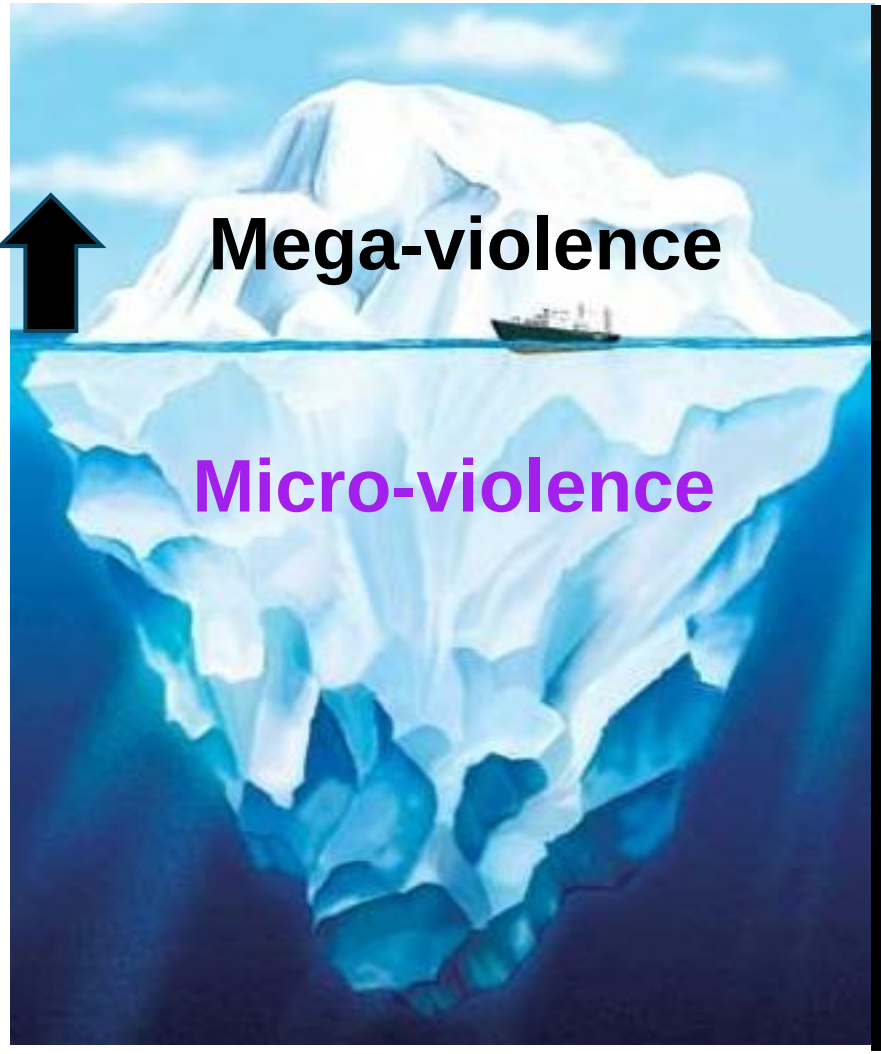
Underlined also target of Disruptive Behaviors: "Behaviors that undermine a Culture of Safety", The Joint Commission, Sentinel Event Alert July 2008

Aggression/ Violence as Continuum

Law /society's common perception of violence:

Severe transgressions against individuals.

Below the line of law/ society usual definitions of violence.
NIOSH/ OSHA Workplace Violence and WHO's definition of violence.
Cause micro-traumas which are <u>additive</u> and <u>cumulative</u>.



Mega-violence <u>examples:</u>

Homicide, assault, threats of harm, terrorism, etc.

Micro-violence <u>examples</u>:

Incivility
Disrespect
Deprivation of human needs
Disruptive Behaviors (TJC)
Belittlement
Bullying,
Micro-aggression
Micro-insult
Micro-invalidation.
Badgering, hassling, persistent cumulative expectations that effectively bully both leaders and clinicians into compliance.
Non human-centered, poorly designed work procedures, policies, mandates, laws, regulations, must be done, lack of control.
Toxic management behaviors.

Privitera, M.R., Bowie, V. and Bowen, B. (2015) Translational Models of Workplace Violence in Health Care. *Violence and Victims*, **30**, 293-307.

World report on violence and health (2002). Geneva, Switzerland: World Health Organization; Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/

Workplace Violence Typology Comparison

Cal / OSHA[1]	Bowie Expansion[2]
Type I: Criminal intent-intrusive violence	**Type I:** Criminal intent-intrusive violence
Type II: Customer/client violence	**Type II:** Customer/client violence
Type III: Worker-on-worker violence **Type IV:** Personal relationship violence	**Type III:** Relationship violence: Worker-on-worker + Personal relationship violence.

Type IV: Organizational Violence — against staff, consumers/ clients/ patients (the ways organizations are structured and managed).

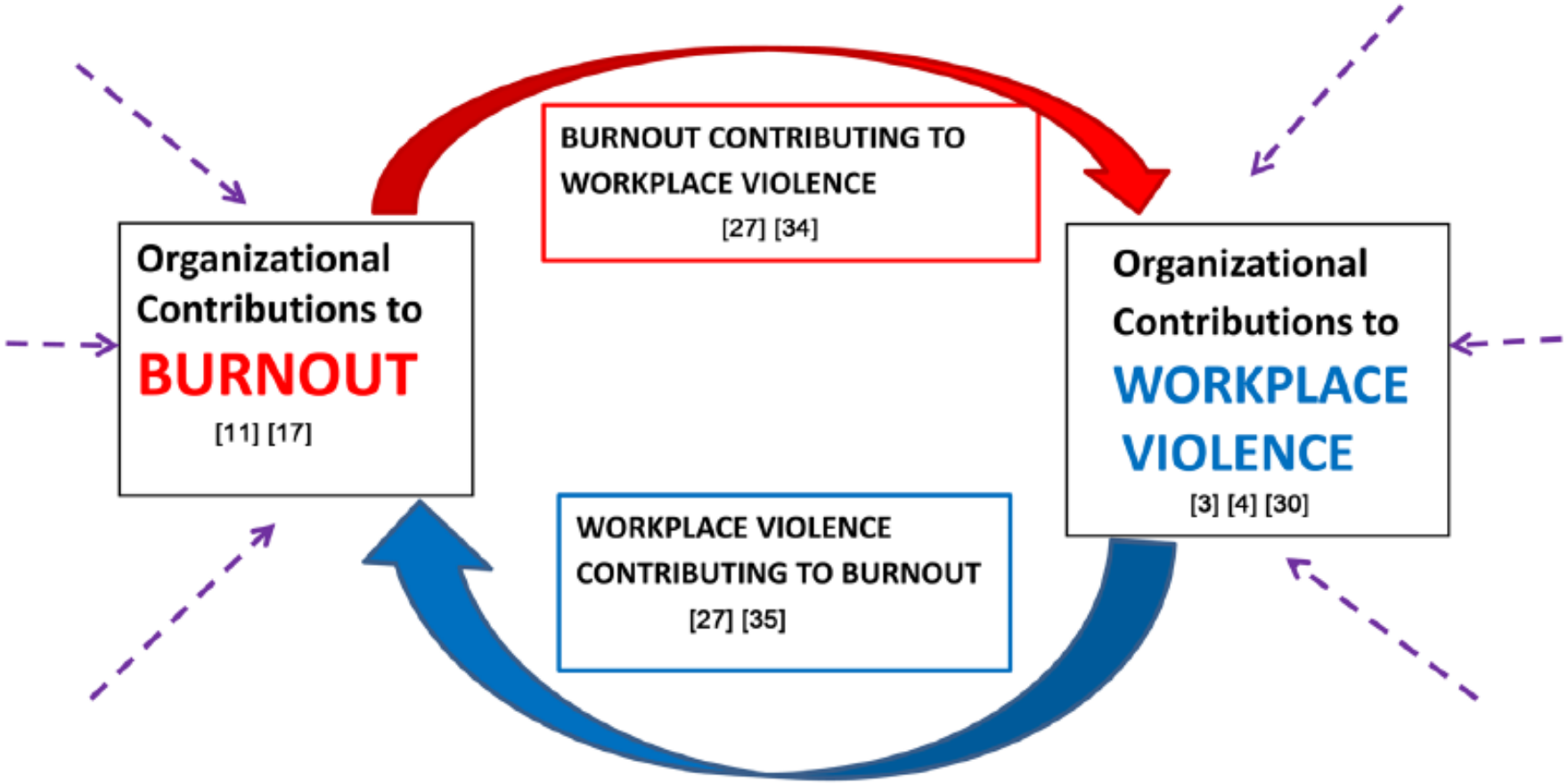
From: Parrinello K, Miller KD. Workplace Violence in the Healthcare Setting –An Administrative Perspective. In Privitera MR Workplace Violence in Mental and General Healthcare Settings. Jones and Bartlett Publishers ©2011 pp 59-71.
1) California Occupational Safety & Health Administration (Cal/OHSA). Cal/OSHA Guidelines for Workplace Security. San Francisco, CA: State of California Department of Industrial Relations, California Division of Occupational Safety & Health; 1995.
2) Bowie V. Defining violence at work: a new typology. In: Gill M, Fisher B, Bowie V, eds. Violence at Work—Causes, Patterns, & Prevention. Devon, England: Willan Publishing; 2002.

Factors Affecting Difficult Relationships

Patient Factors	Clinician Factors	Healthcare System Factors
Psychiatric disorder. Personality issues. Subclinical behavioral traits. Low resources for self care. Coming in with past struggles to get care, Sensitized to perceiving inadequate help provided. Entitlement amplification by current "patient satisfaction"/customer service environment of HC Reform.	Overwork, Burnout depersonalization, emotional exhaustion. Poor communication skills. Low level of experience. Discomfort with uncertainty. Overly paternalistic. Not do well with challenge to opinion.	Productivity pressures, business emphasis. Value gap between administrators and clinicians. Changes in HC system financing. Fragmentation of visits. Poor design of electronic and systemic workflows. Outside challenges to clinician authority Hidden criteria for pre-authorization, etc. Inadequately addressing clinician satisfaction and engagement. Poor Organizational Health.

Adapted from Haas LJ, Leiser JP et al.
Management of the Difficult Patient.
American Family Physician 72(10):20163-2068.
November 15, 2005.

Vicious Cycle of Workplace Violence and Burnout



[3] Bowie, V. (2011) An Emerging Awareness of the Role Organizational Culture and Management Style Can Plan in Triggering Workplace Violence. In: .Privitera, M.R., Ed., *Workplace Violence in Mental and General Healthcare Settings* ,Jones and Bartlett Publishers, Sudbury, 43-58.

[4] Privitera, M.R., Bowie, V. and Bowen, B. (2015) Translational Models of Workplace Violence in Health Care. *Violence and Victims*, **30**, 293-307.

[30] Bowen, B., Privitera, M.R. and Bowie, V. (2011) Reducing Workplace Violence by Creating Healthy Workplace Environments. *Journal of Aggression Conflict and Peace Research*, **3**, 185-198. http://dx.doi.org/10.1108/17596591111187710

[27] DiMartino, V. (2003) Relationship of Work Stress and Workplace Violence in the Health Sector. Joint Programme on Workplace Violence in the Health Sector.

[35] Estryn-Behar, M., van der Heijden, B., *et al*. (2008) The NEXT Study Group. Violence Risks in Nursing—Results from the European "NEXT" Study. *Occupational Medicine*, **58**, 107-114. http://dx.doi.org/10.1093/occmed/kqm142[

11] Maslach, C. and Leiter, M.P. (1997) The Truth About Burnout. How Organizations Cause Personal Stress and What To Do About It. Jossey-Bass Publishers, San Francisco.

[17] Privitera, M.R., Rosenstein, A.H., Plessow, F. and LoCastro, T.M. (2015) Physician Burnout and Occupational Stress: An Inconvenient Truth with Unintended Consequences. *Journal of Hospital Administration*, **4**, 1-8

[27] DiMartino, V. (2003) Relationship of Work Stress and Workplace Violence in the Health Sector. Joint Programme on Workplace Violence in the Health Sector.

[34] Chen, P.Y. and Spector, P.E. (1991) Relationships of Work Stressors With Aggression, Withdrawal, Theft and Substance Abuse: An Exploratory Study. *Journal of Occupational and Organizational Psychology*, **65**, 177-184. http://dx.doi.org/10.1111/j.2044-8325.1992.tb00495.x

What is Burnout?

Burnout is a syndrome resulting from chronic workplace stress that has not been successfully managed.

Characterized by 3 dimensions:

1. Feelings of energy depletion or exhaustion.

2. Increased mental distance from one's job or feelings of negativism or cynicism related to one's job and

3. Reduced professional efficacy

World Health Organization
https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

Medical Error and Clinician Burnout: Both Have Systemic Contributions

- **Majority of errors** in healthcare are result of systemic influences.[1] The Institute of Medicine (IOM) 1999 Report, *To Err is Human: Building a Safer Health System*

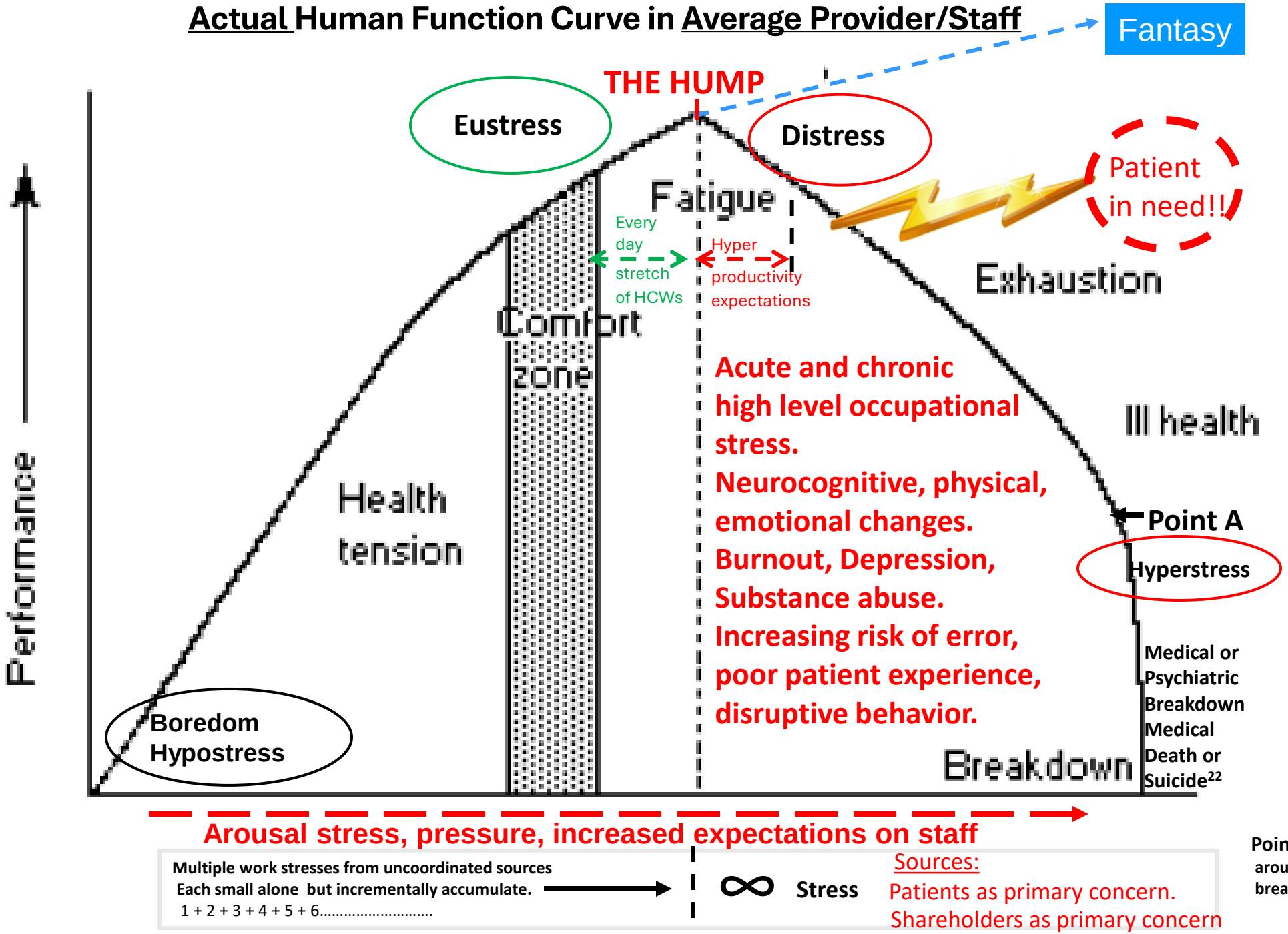
- **The majority of occupational stressors causing burnout** are result of systemic factors.[2]

- **The quality paradox:** Many well-intended interventions to improve quality, safety or value, *when taken in total*, are contributing to health system dysfunction by cumulative impact on workload and burnout at the point of care.[3]

- The higher the **cognitive load** the higher the risk of **burnout**[4]
- The higher the **cognitive load** the higher the risk of **medical error**[5]

1. Kohn, L.T., Corrigan, J., Donaldson, M.S. , *To err is human: building a safer health system.* 2000, Institute of Medicine. National Academy of Sciences: Washington, D.C
2. Privitera MR, Attalah F, et al . Physicians' electronic health record use at home, job satisfaction, job stress and burnout. 2018 Journal of Hospital Administration. Vol 7, No 4.. 52-58
3. Sinsky CA and Privitera MR. Creating a Manageable Cockpit: A Shared Responsibility. JAMA Int. Med . June 2018.; 178(6):741-42
4. Harry E Sinsky C et al. Physician Task Load and Risk of Burnout in US Physicians in a National Survey. The Joint Commission Journal of Patient Safety 2020 000: 1-10.
5. Pickering BW, Herasevich V et al. Novel Representation of Clinical Information in the ICU. Appl Clin Inform 2010 1(2) 116-131

Actual Human Function Curve in Average Provider/Staff



Point A = even minimal arousal can precipitate breakdown

Figure 1. Adapted from: Nixon PGF. The Practitioner. (217):765-770. 1976[23]

The Impact of Clinician Burnout

Institutional & Patient Effects

- Increased risk of medical errors (200%)
- Increased malpractice claims
- Disruptive behavior
- Reduced empathy for patients
- Reduced patient adherence to treatment regimens
- Reduced patient satisfaction

Financial Effects

- 27% drop in patient satisfaction scores
- 40% of turnover costs attributed to work stress
- 114% increase of medical claims by employees.
- 30% of short-term and long-term disability costs

Spearman's rank correlation coefficient **0.628, p < 0.001***

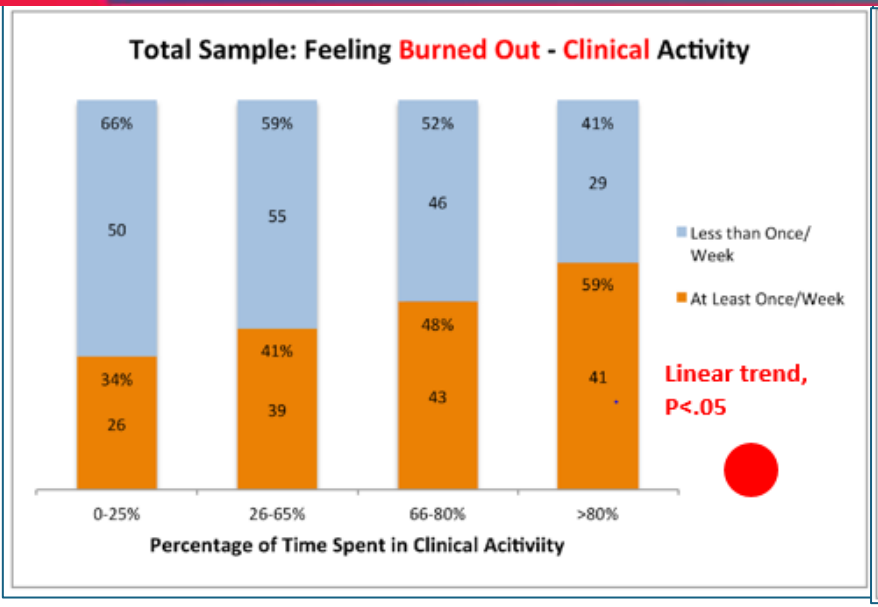
Personal Effects

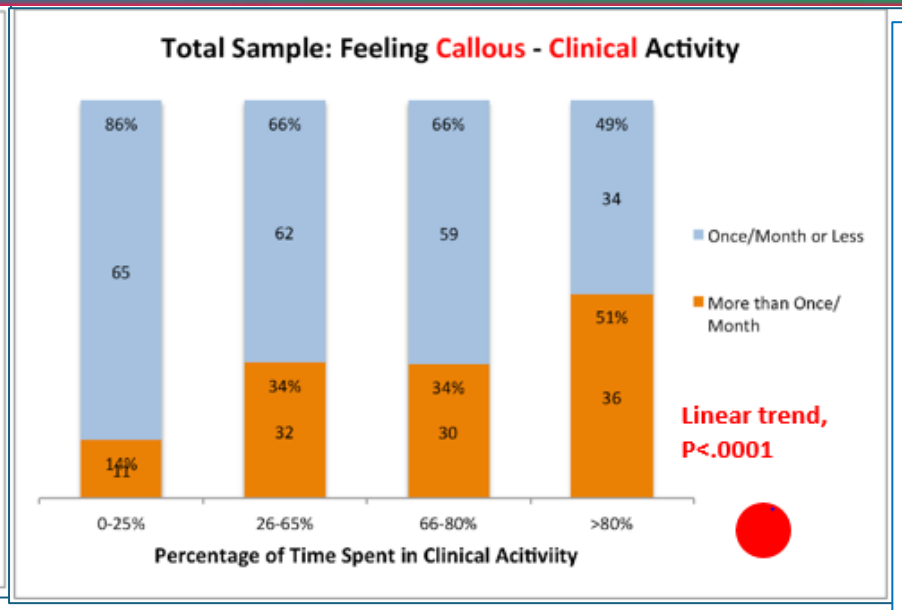
- Higher Suicide Rate among physicians- 400/yr.
- Substance abuse
- Divorce
- Coronary Heart Disease: CHD 1.4 fold up to 1.79 at high burnout levels
- Brain injury from uncontrolled stress
- Reduced career satisfaction

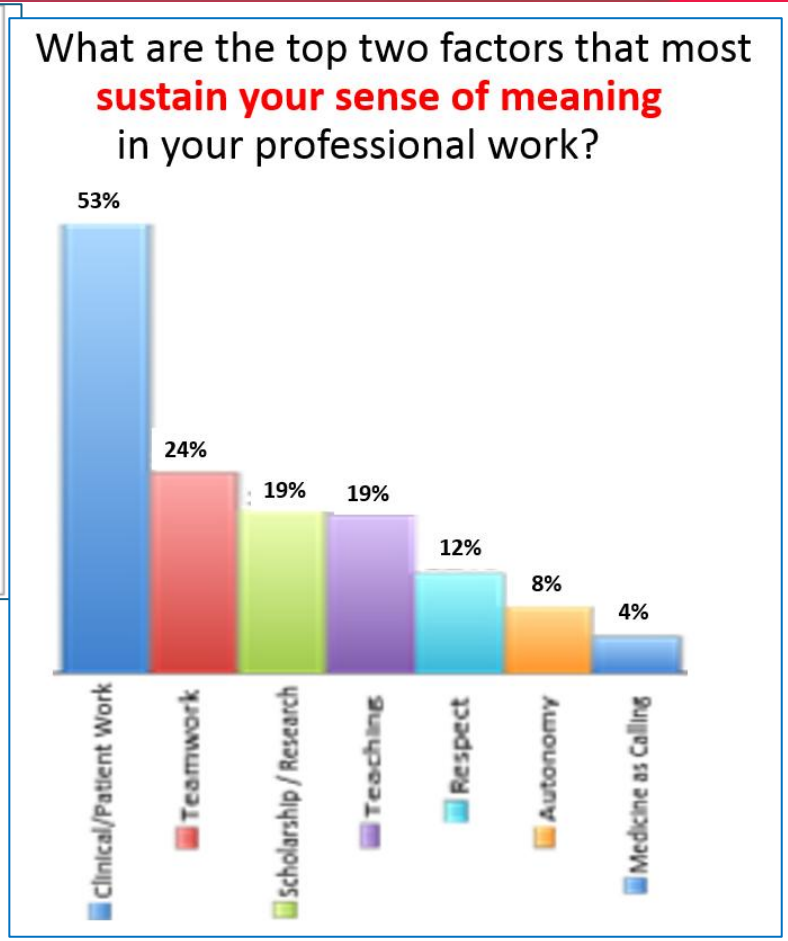
*Devoe J, et al. Med Care. 2007 January ; 45(1): 88–94.

The Greater the % Clinical FTE, the Greater the Burnout (dose related to clinical exposure)

Paradox- Most Frequent Factor that Sustains Sense of Meaning is Patient Care/Clinical Work







Conclusions:

1. **Something(s) are <u>in the way</u> of clinicians taking care of their patients.**
2. **Write in questions show <u>things in the way</u>:**

   High expectations from systemic/ organizational (national, state, industry, regulatory) mandates, leadership not aware of personal impact on them- and into their home life, regulations, EMR design, education requirements without allocated time to do them, difficult workflows.

Data from: Anandarajah A, Quill T, Privitera MR. Adopting the Quadruple Aim: The University of Rochester Medical Center Experience. Moving from Physician Burnout to Physician Resilience. American Journal of Medicine Aug 131 (8) 979-986. 2018

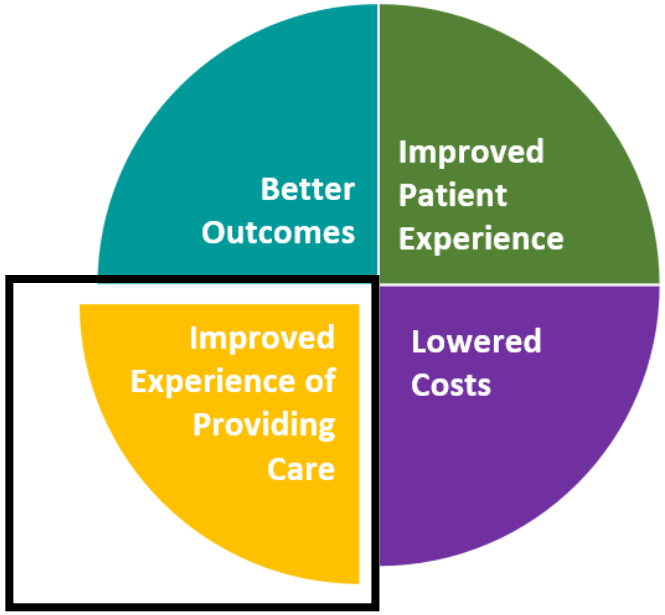
Contributory Influences in US Healthcare Delivery Framework

- 1999-"To Err is Human" (IOM)
- 1990s-Patient Safety Movement- just get it right
  - 2000 Leap Frog Group (Business Consortium) influencing healthcare financially-pursuing "value"
- 2003- Centers for Medicare and Medicaid (CMS) Pay for Performance (P4P) "Quality Metrics"
  - 2009 Meaningful Use Criteria
    - 2010 Affordable Care Act
- **2013 William Spinelli: "Burnout is the phantom limb pain of the Triple Aim*".**
- **2023 CDC/NIOSH Impact Wellbeing Guide: "Integrate Professional Wellbeing into Quality Improvement"—** As a quality metric, should be included in payment systems.

Triple Aim 2008

- 2010 Triple Aim Framework comes to payment systems:
- Centers for Medicare and Medicaid (CMS) -

Quadruple Aim 2014



Quintuple Aim 2016

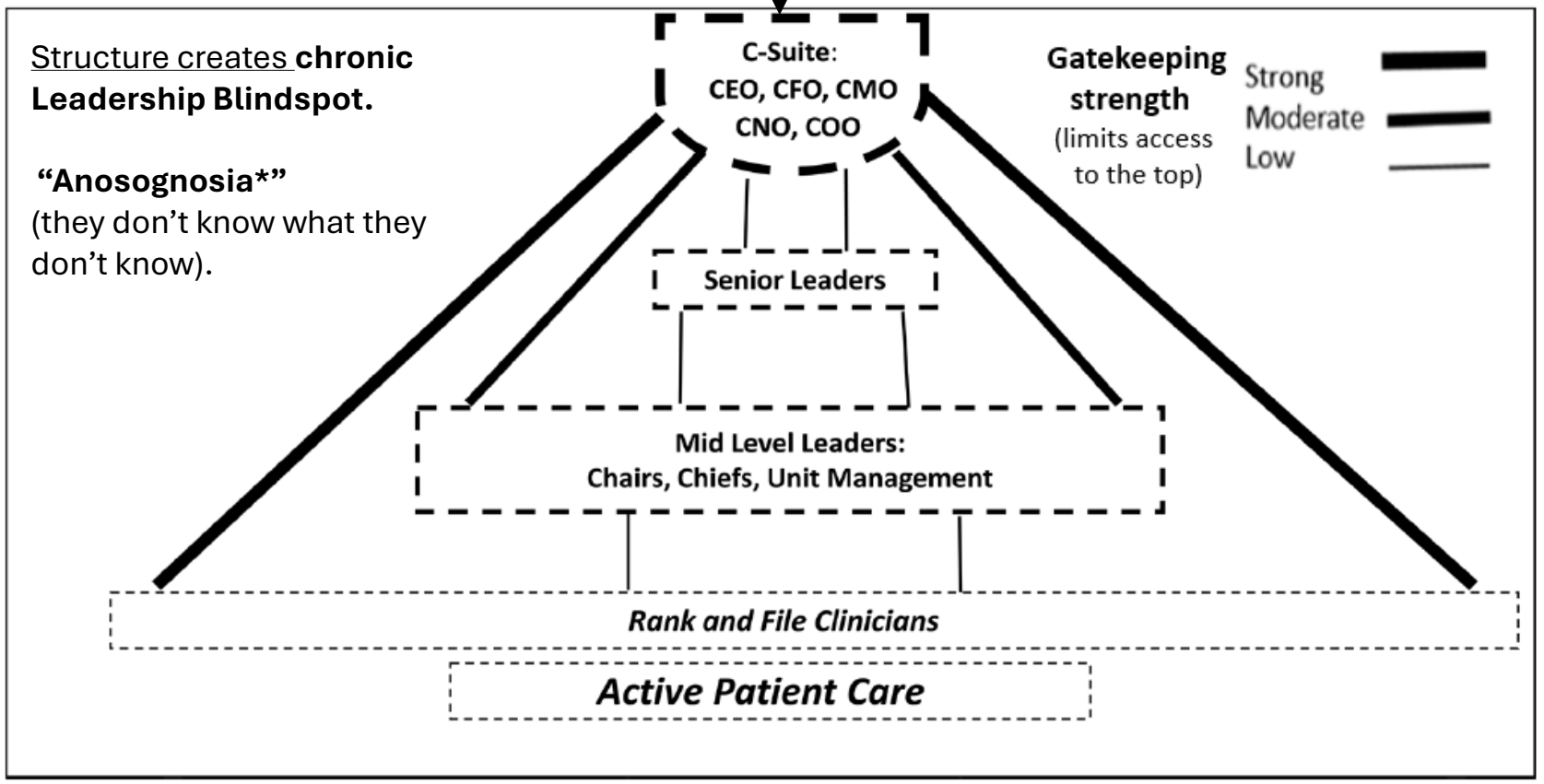
Payment system still remains Triple Aim based→ → →

- **Experience of Providing Care (Human Factors/Ergonomics in providing care)**
  Important as guide to device design companies, regulators, legislature and other decision-makers

*Spinelli W. The phantom limb of the triple aim Mayo Clin Proc . 2013 Dec;88(12):1356-7. doi: 10.1016/j.mayocp.2013.08.017.

Communication Flow in Medical Centers

National, State, Local Authorities, Regulators, Accreditors, Payers, Industry thought leaders, Healthcare Consultants, etc.
Directly Influence Healthcare Leadership (C-Suite).



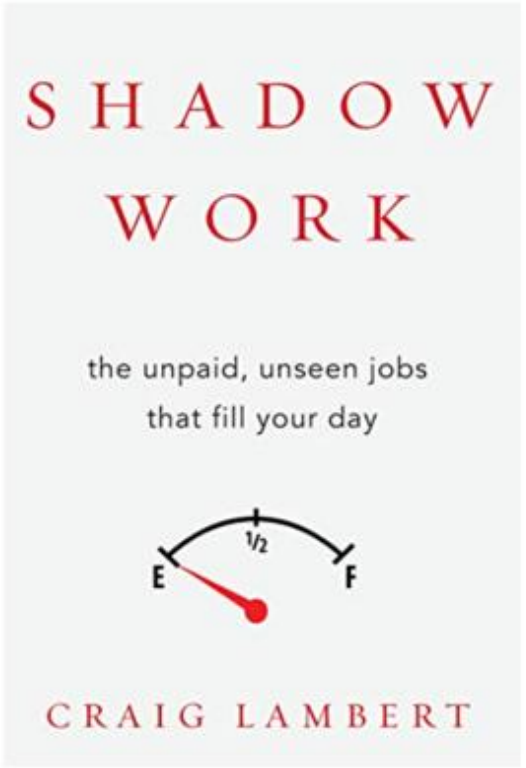
Communication flow to clinicians and staff.

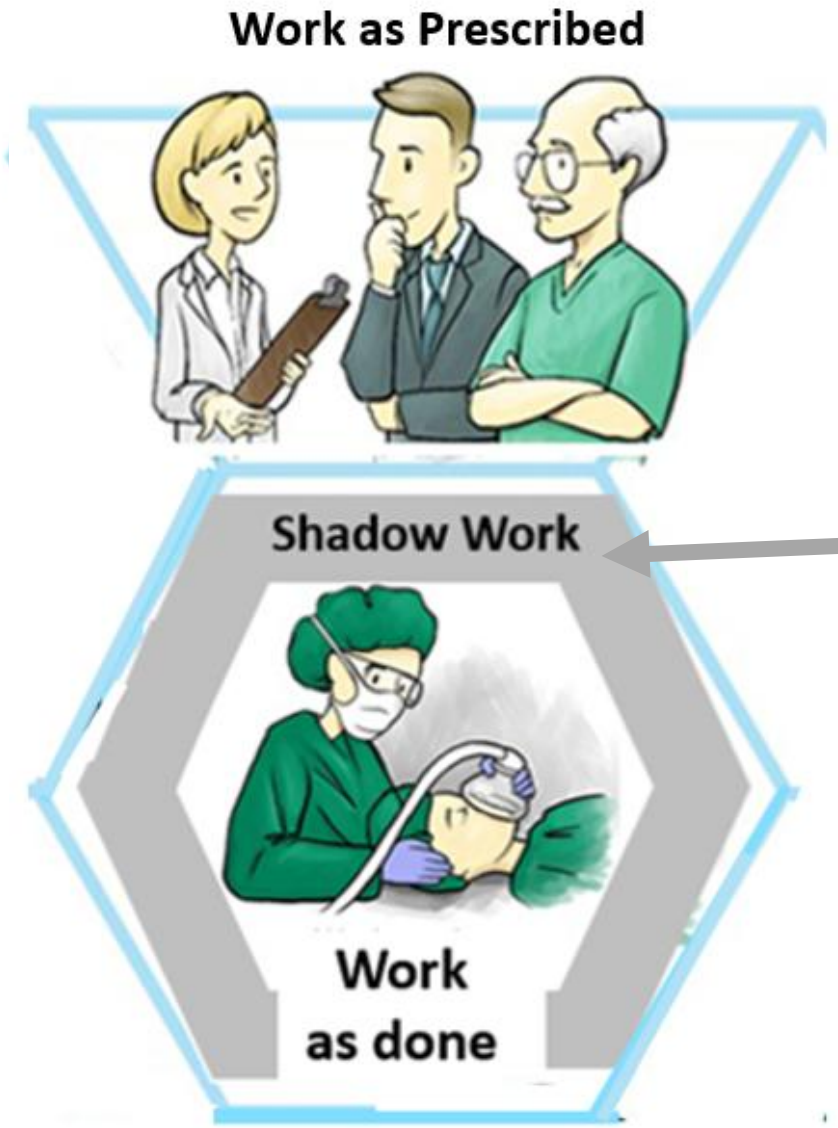
Missing: Feedback information systems to Leadership and should encourage Psychosocial Safety in Culture.

*__Anosognosia__= In neurology is a **lack of awareness of deficits** due to brain injury (often right hemispheric stroke)
Body's **feedback system** was **damaged**, don't get needed information to the brain to make best self-protective decisions.

Gap between **Work as Prescribed** and **Work as Done**

Work as Prescribed + Shadow Work = Work as Done





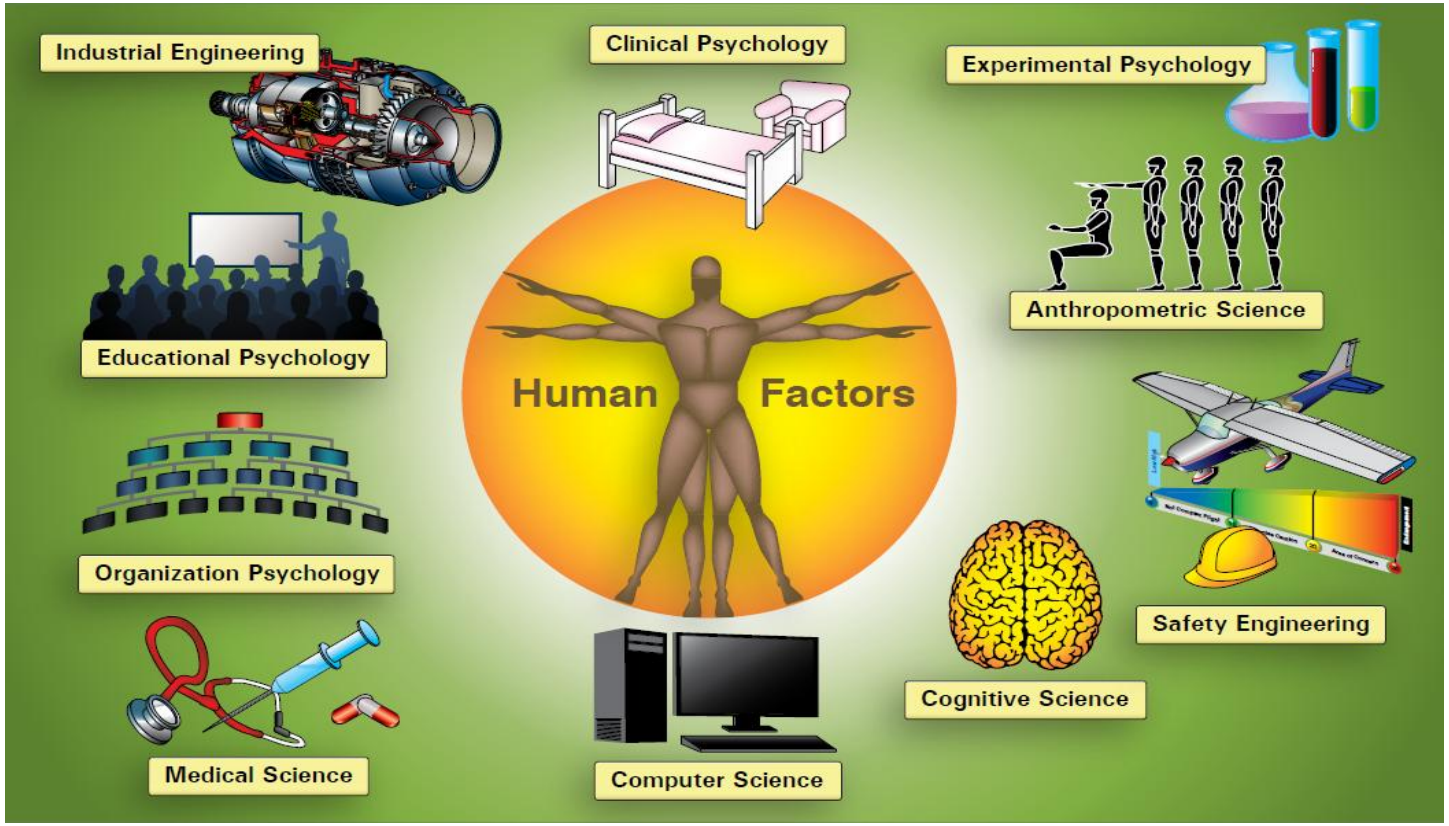
Job Metrics only pick up:
"productivity" units:

Shadow Work:
Unseen, unpaid jobs that fill their day. **Work not "seen" in system metrics**.
Efforts by staff- behind the scenes- making up for system deficits to keep it functional.

Major source of unnecessary Cognitive Load.

Varies one location to another (due to local management decisions). However, job metrics from one institution to another get compared (inaccurately).

What Are Human Factors / Ergonomics (HFE)?



https://www.faasafety.gov/files/gslac/courses/content/258/1097/AMT_Handbook_Addendum_Human_Factors.pdf

Chapter 14 Human Factors FAA Safety

HFE Definition: The scientific discipline concerned with understanding interactions among humans and other elements of a system.

- **3 Major Types of Ergonomics**:
  - Physical
  - Cognitive
  - Organizational
- Applies theory, principles, data, and methods to:
  - Optimize **human well-being AND system performance.**
  - **Patient safety** is a component of system performance.
  - **Goal**:

    Fit the system to the people

    instead of

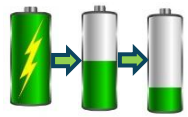
    fitting people to the system

What is Cognitive Load (CL)?

- Measure of information held and processed in Working Memory at one time.
- Total CL has three divisions: **Intrinsic**, **Germane** and **Extraneous Cognitive Load**.
- Higher the Total CL → more brain resources consumed.
- All humans have **limited Cognitive Load Capacity**.
- If exceeded capacity can lead to medical error.

1. Harry E, Sweller J. Cognitive Load Theory and Patient Safety. In Ruskin KJ, Stiegler MP and Rosenbaum SH. Quality and Safety in Anesthesia and Perioperative Care. 2016. pp 16-21. Oxford University Press.

Individual Task-Specific Cognitive Load



Task Healthy Load

Cognitive capacity

Individual Task Related Cognitive Load

Intrinsic Cognitive Load: inherent level of cognitive difficulty; immutable

Germane Cognitive Load: Exertion of making mental model into Long Term Memory

Extraneous Cognitive Load: Can be removed with better design, appropriate expectations

Mental Reserves

Overload

Work demands exceed neural (brain) resources.

Risk for errors increase greatly.

Individual Task Related Cognitive Load

Intrinsic Cognitive load: Inherent level of cognitive difficulty; immutable

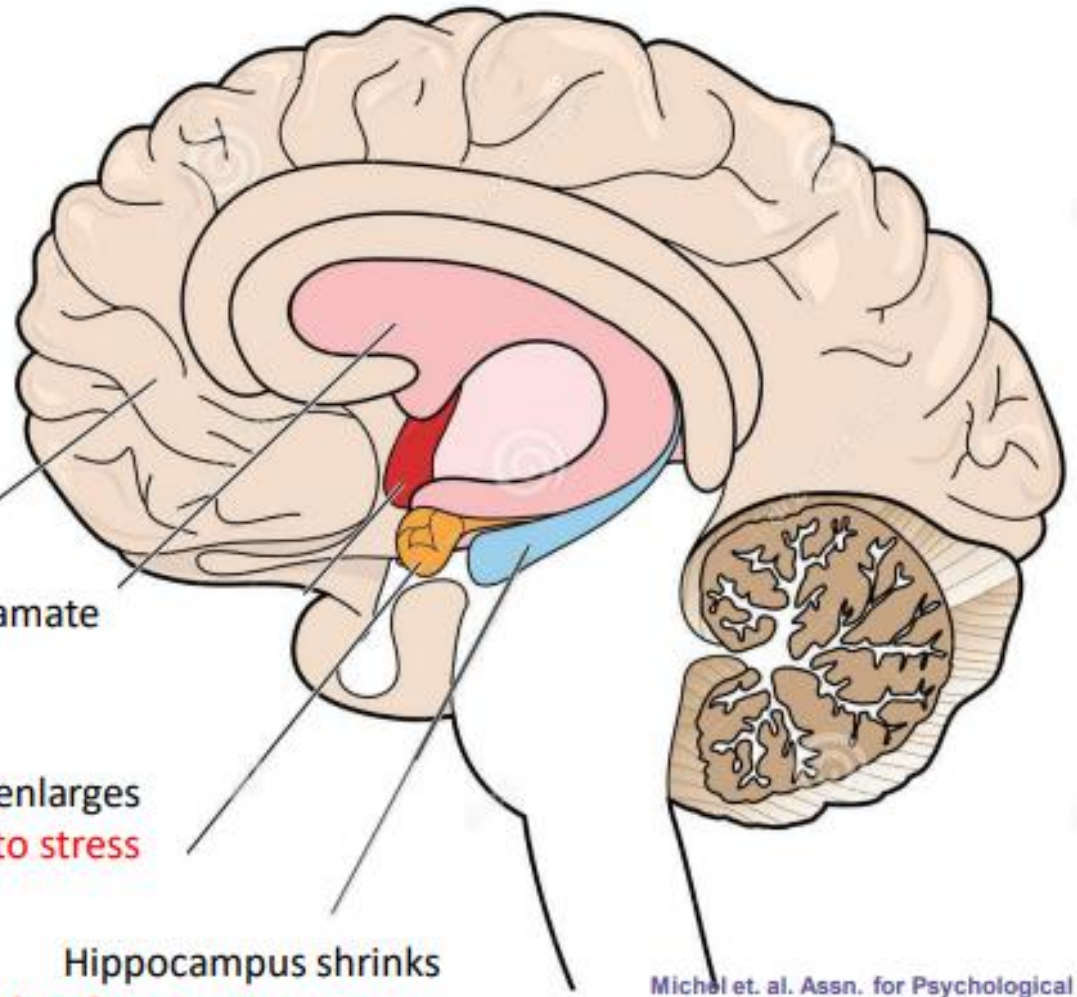
Germane load: Exertion of making mental model into Long Term Memory

Extraneous Cognitive Load: Can be removed with better design, appropriate expectations

These Occur In Overload:

- **Automatic thought-** learned response from stimulus. No differential diagnosis
- **Load shedding-** offload information, first low risk, then random shedding
- **Goal shielding-** not allow new information into brain processing (over-focused on achieving goal)

Brain Biological Effects of Burnout



Thinning of the **Pre-frontal Cortex**
↓ ability to focus, quality of medical decision-making

Decreased grey matter of **Basal Ganglia** from excess glutamate
↓ fine motor control

Amygdala enlarges
↑ reactivity to stress

Hippocampus shrinks
↓ short-term memory, then long-term memory

Michel et. al. Assn. for Psychological science 2016
Savic et. al. Cerebral Cortex 2015
Alkadhi et. All ISRN Physiology 2013
Golkar A et al PLoS ONE 2014

Privitera M. and Shah T.

Neurobiology of Clinician Distress and Burnout (I)

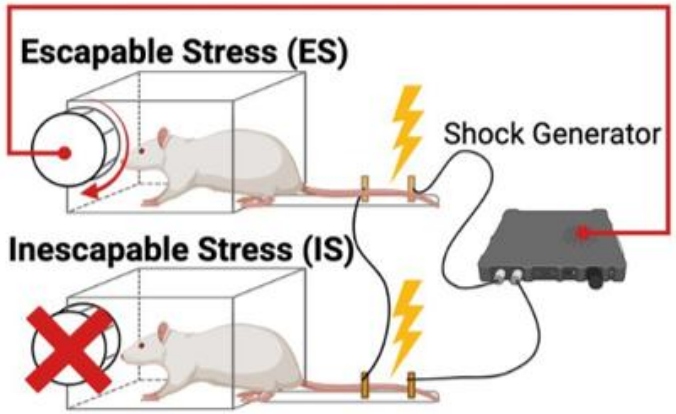
- Burnout linked to **uncontrolled stress** coming from reduction of a clinician's sense of control over their own practice[1].
- **Uncontrollable stress** (*but not controllable stress)* impairs the functioning (and structure) of the prefrontal cortex (PFC)[1].
- **Exposure to chronic stress:** Cascade of events leading to cerebrovascular dysfunction.
- Leads to structural and functional effects like Hypertension HTN):
  Endothelial injury, increases wall thickness, vessel resistance, stiffness, arterial atherosclerosis and impairs cerebral blood flow "auto-regulation"[2].

1.Amy F.T. Arnsten, PhD, and Tait Shanafelt, MD Physician Distress and Burnout: The Neurobiological Perspective Mayo Clin Proc.2021;96(3):763-769
2. Nada Elsaid, Ahmed Saied, Heba Kandil et al. Impact of stress and hypertension on the cerebrovasculature.. Frontiers in Bioscience-Landmark 26(12). 1643-1652, DOI:10.52586/5057.

Animal and Human Research

Brain performance, anatomy and physiology affected by:

- ***Uncontrolled stress***: Out of the control of the subject to escape from or end the stress.



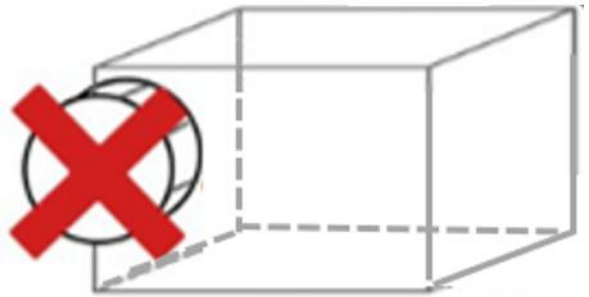
Uncontrolled, inescapable Stress
Rats restrained and given tail shocks

Human

High risk for impact on brain structure and function.

+

Clinical Career



Career requires high investment.
Creates situation like being restrained, trapped.

- Calling of Medicine, dedication
- High personal commitment and sacrifice
- 21 years of education
- High training/education debt
- Driven to push self try to overcome odds
- Medical culture of endurance and silence

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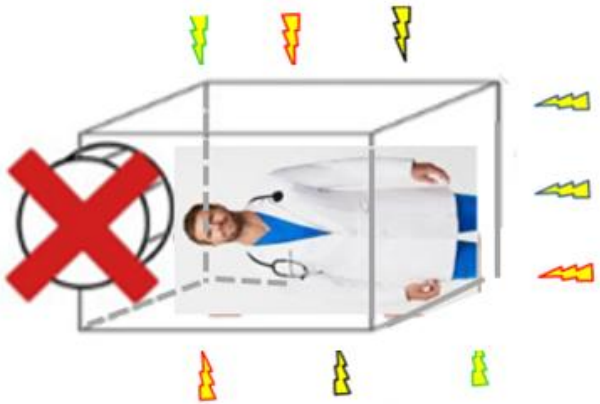
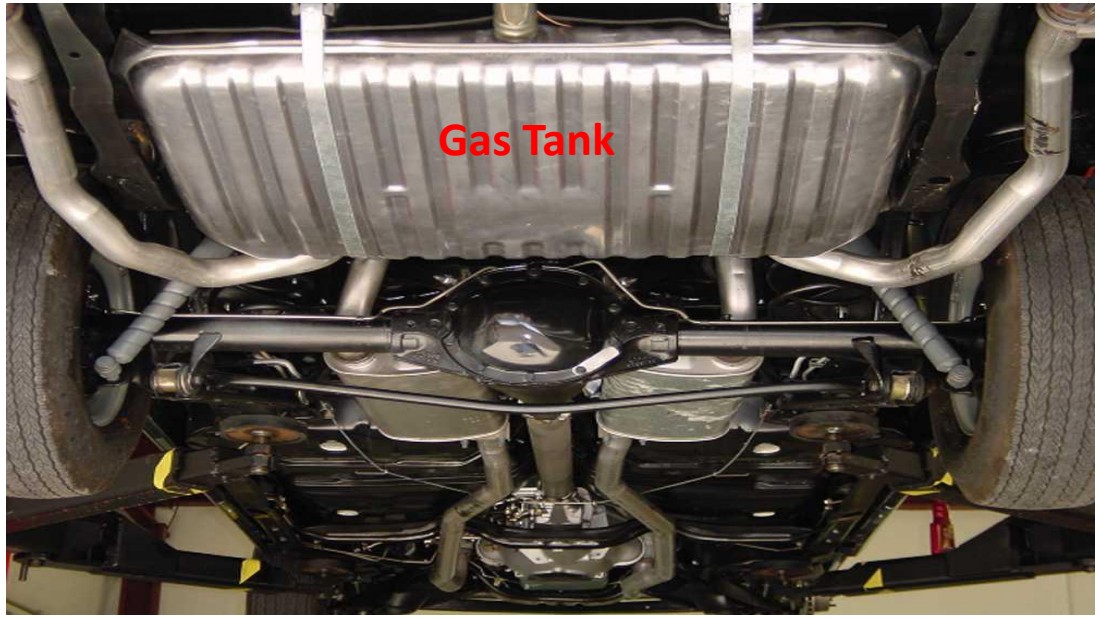


Work environment:
High level, chronic inescapable stressors

Career and financial survival controlled by multiple external authorities. "Bullying –equivalents" Career jeopardy by frequently expiring mandated credentials to work or prove competence to others.

Chronic High Occupational Stress Condition at Work- Metaphor



Gas Tank Metaphor
Rested, fed, healthy human clinician.

Large Gas Tank filled:

- Now to face high occupational stressor expectations.

Gas Tank - Shrunken
Burned out, depressed, anxious, sleep deprived, unfed human clinician.

Smaller capacity created by chronic wear-down.
Less brain resource to achieve same expectations.
Starting out with less capacity yet to face high occupational stressor expectations.

Neurobiology of Clinician Distress and Burnout (II)

- Understanding this neurobiology:
  - Helps perspective of clinicians and administrators to relieve or prevent burnout[1]

- Helps administrative leaders optimize the work environment to create more effective organizations.[1]

- Efforts to restore a SENSE OF CONTROL ("aligned autonomy") to physicians may be particularly helpful[1].

1.Amy F.T. Arnsten, PhD, and Tait Shanafelt, MD Physician Distress and Burnout: The Neurobiological Perspective Mayo Clin Proc.2021;96(3):763-769
.

Demand-Resource Model

Burnout

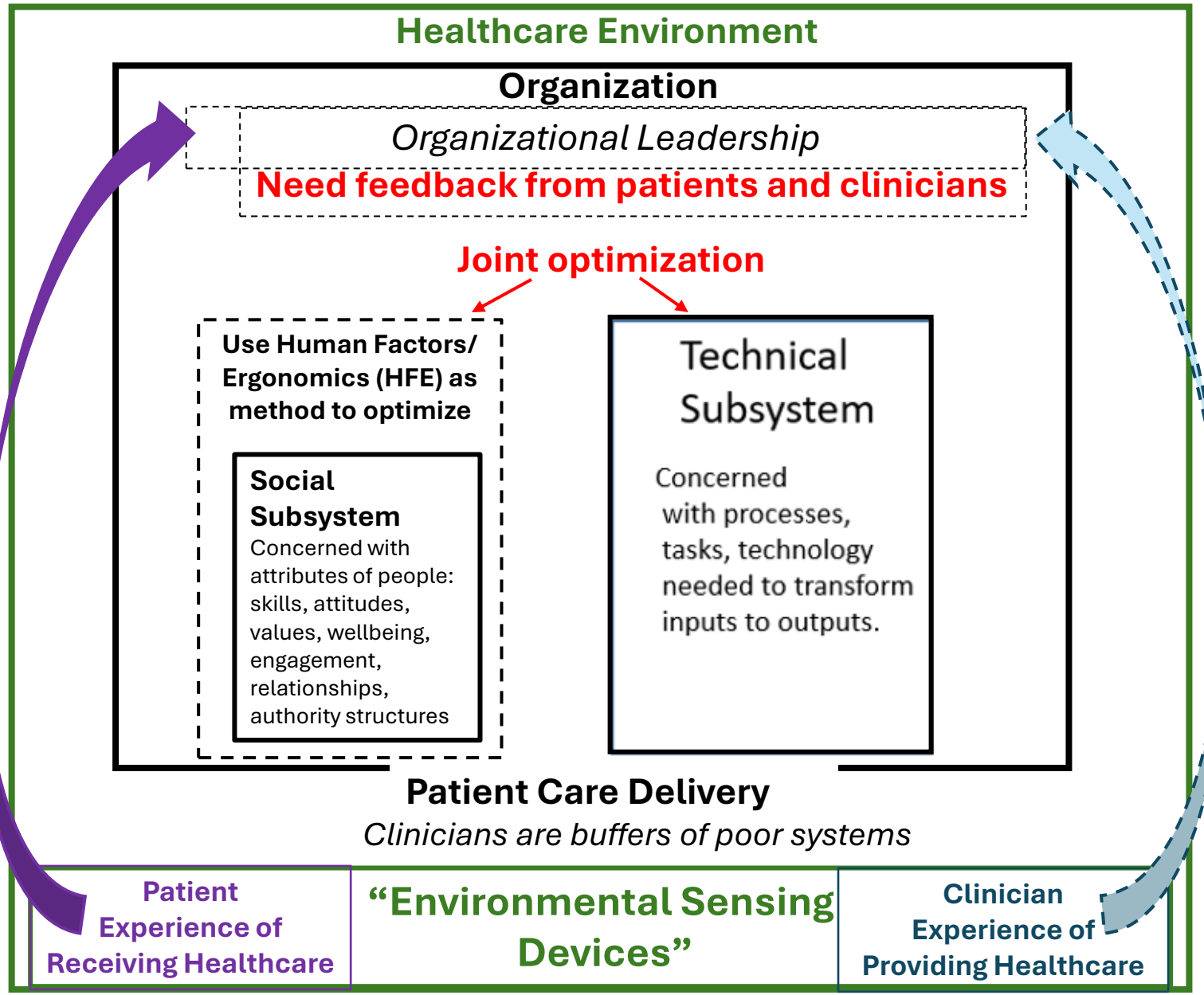
- Reduce in number
- Reduce Extraneous Cognitive Load
- Simplify
- Satisfice
- Harmonize with existing demands.
- Collaborate
- Coordinate
- Boundary between work and home
- Distinguish virtuous work from non-value added work.

Job Demands > **Job Resources**

- Time allocation
- Restoration (cognitive, emotional physical, moral)
- Instrumental support
- Superior support
- Emotional support.

Based upon Demerouti 2001

Sociotechnical System (STS) Perspective: Designing Effective Organizations



-**Patient Experience** feedback to Organizational Leadership

-**Clinician Experience** feedback: **Needed but not yet developed**

-No metrics immediately tied to financial survival.

-Medical Culture of Endurance and Silence impairs.

-Hierarchy and gatekeeping Impairs.

-Reduced awareness and acknowledgement of overwhelm.

Real or perceived **"access to the Top" who have decision-making power to reduce the stress** has a brain protective effect and improves performance under stress*.

*Glass DC, et al. Journal of Experimental Social Psychology. 1971 7. 244-257.

From Privitera MR. Promoting Clinician Wellbeing and Patient Safety Using Human Factors Science :Reducing Unnecessary Occupational Stress. Health 2022. (14) 1334-1356

Healthcare Ecosystem

Macro Level-
National, state, industry, regulatory

Well-intended
EMR- not well designed.
Multiple Quality Metrics
Patient Safety Movement.
Mandatory education initiatives
Patients as primary concern

Many Authorities In Healthcare

Not so well-intended
Hassle Factors by Insurance **intended** to wear down clinician,
For-profit Agendas.
Healthcare as investment vehicle.
Shareholders as primary concern

Meso Level-
Hospital/ Healthcare Organization

Administrative Task demands:
Mandatories, policies, laws, regulations, quality metrics, billing, prior auth's, workflow issues, EMR software

Opportunity for control of HOW these are implemented.
Will make a difference to clinicians' wellbeing and brainpower needed for taking care of patients.
Remove ECL, optimize GCL. ICL remains and meets requirements.

Each authority is silo of operation. No over-arching authority aware of total combined mandatory requirements , laws, policies, guidelines imparted—**except at level of hospital leadership**

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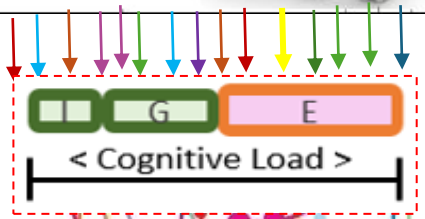


Administrative Task demands: Mandatories, policies, laws, regulations, quality metrics, billing, prior auth's, work flow issues, EMR software

Meso Level-

Hospital/ Healthcare Organization

Hospital Leader Pathway

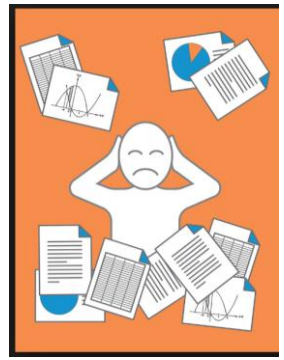
Business as Usual → 1

Apply HFE 2

Human Factor Based Leadership

Programs to Reduce Extraneous Cognitive Load

Individual Clinician Based approach



Micro Level-

Individual clinician with patients and staff

Staff have more brain power for clinical work.

Work outside of Work minimized.
Off time protected. **Physical emotional and cognitive restoration.**

Organization-Based approaches

Burnout Interventions: Need Both

Individual-based Interventions

- **Recognition of Burnout despite Culture of Endurance and Silence**
- **Individual interventions must be paired with organizational interventions**
- **Normalize boundaries between work and home despite technology-> Policy and culture supportive.**
- **Multiple individual interventions**
  - Mindfulness-based stress reduction
  - Gratefulness
  - 3 Good Things etc.
  - Peer Support program
  - Clinician ombudsman to have work/life balance representation

Organizational Interventions

Address Experience of Providing Care

- **Leadership:**
  - **Style and concern is key**
  - **Commitment to action**
  - **Understand and act upon the front- line problems**
  - **Encourage stronger administrator/physician partnerships**
- **Measure Burnout/ Wellbeing/Satisfaction**
- **Relate these to quality of care, reduction of errors, malpractice and patient satisfaction**
- **NIOSH/CDC "Impact Wellbeing" Guide**

CDC/NIOSH: Impact Wellbeing™ Guide:
Taking Action to Improve Healthcare Worker Wellbeing

Explore the Guide's Six Actions

Action 1

Review Your Hospital's Operations

Action 4

Communicate Your Commitment to Professional Wellbeing

Action 2

Build Your Professional Wellbeing Team

Action 5

Integrate Professional Wellbeing into Quality Improvement

Action 3

Break Down Barriers for Help-Seeking

Action 6

Develop Your Long-Term Professional Wellbeing Plan

https://www.cdc.gov/niosh/healthcare/impactwellbeingguide/index.html

Brewing Legal issues: Employer Duty to Reduce Burnout, Uncontrolled Occupational Stress.

The Duty to Prevent Emotional Harm at Work: Arguments From Science and Law, Implications for Policy and Practice

Martin Shain
Centre for Addiction and Mental Health

Journal of Business Systems, Governance and Ethics *Vol 5, No 3*

Corporate Responsibility for Systemic Occupational Stress Prevention

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AVAILABLE BY PHONE OR CHAT 24/7

Health Care System Causing Dangerous Burnout Among Doctors and Nurses

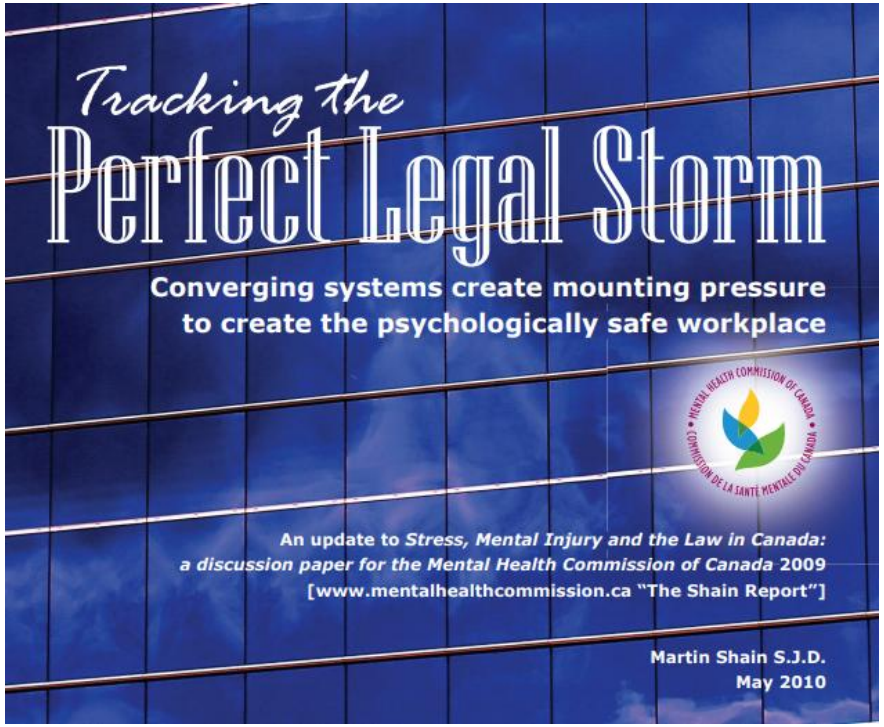
Suing for Emotional Distress at Work

Can I File a Workers Comp Claim for Burnout?

November 21, 2022 By James Hoffmann

2025 National Working Group: Duty to Protect Healthcare Workers From Uncontrolled Stress.

American Bar Association, American Medical Association Atalan on Economic impact of Burnout, Lorna Breen Heroes Foundation, URMC contributors.



SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Healing the Healers: Legal Remedies for Physician Burnout

Sharona Hoffman

Case Research Paper Series in Legal Studies
Working Paper 2018-10
September 2018

Overlap of Organizational Contributions to Burnout and Workplace Violence (WPV): Is This an Opportunity to Sustain Prevention of Both?

- **Burnout** in healthcare workers (HCW), effect on patients and institution is experienced **DAILY.**
- **Workplace violence (WPV)** has a spectrum of forms.
  - In extreme forms it generally is **LOW FREQUENCY /HIGH IMPACT** occurrence.
  - Concern acutely rallies but trails off due to competing demands
- Efforts to reduce Burnout are more likely to sustain because of impact **DAILY.**
- Efforts to reduce WPV as **LOW FREQUENCY** event are harder to sustain despite best intentions.

Could efforts to reduce the common factors of organizational contributions to Burnout and WPV be a strategy to sustain prevention of Both?

Privitera, M.R. Organizational Contributions to Healthcare Worker (HCW) Burnout and Workplace Violence (WPV) Overlap: Is This an Opportunity to Sustain Prevention of Both? *Health*, 8, 531-537. 2016 http://dx.doi.org/10.4236/health.2016.86056

Common Factors: Organizational Contributions to Burnout and Workplace Violence

Organizational Contributions to Burnout

Job Characteristics
Job Demands:
-Quantitative: Workload, overtime, time pressure.
-Qualitative: Role conflict , extraneous cognitive load demand (detracting from germane and intrinsic cognitive load needed to do the work).
-Role ambiguity .
Job resources:
-Lack of information, poor communication.
-Lack of control on schedule and workflow issues (little participation in decision making).
-Lack of autonomy , lack of social support.
Organizational and management environment:
-Organizational context shaped by larger social, cultural and economic forces.
-Emotion-work variables: requirement to display or suppress emotions on the job, being "professional", "self-effacement" despite stressors from systems, patient, personal or staff issues.
-Requirement to be emotionally empathic .
-Violation of psychological contract.
How one is treated by the employer and appreciation of what the employee puts into the job- crucial in maintaining staff wellbeing.
Organizational Characteristics:
-Complexities in hierarchies, operating rules, resources, space distribution, space design, fairness and equity, distributive justice of resources.

Common Factors:

Management/ Triage
Resource allocation
Flow design
Cognitive overload/ Administrative toxicity
Communication/ Information
Lack of social support
Lack of control of environment
Emotion management
Emotional work and distress
Psychological contract violation
Physical design issues.
Organizational Trauma

Organizational Contributions to Workplace Violence

-Clash of people/ physical design. Crowding, forced together by difficult circumstances.
-Complexity of system in getting help and effect on cognitive load when in pain and distress.
-Lack of progression/ frustration: waiting without any sense of progression.
-Zero Tolerance Policies (override professional discretion and expertise, reflex reaction to complex problem).
-Perceived inefficiency: Dealing with Electronic Medical Record challenges, documentation requirements, mandates, laws and regulations that are uncoordinated with each other.
-Patients observe themselves and others seemingly waiting for hours while staff "busy themselves" with perceived non-essential tasks.
-Forfeiting of control.
-Lack of information from staff to patients.
-Lack of support during duress .
-Perceptions that hospital/staff in it for the money .
-Staff fatigue: Highly demanding work on staff, over time, physically and emotionally tired, constant flow of patients.
-Human resource shortage undermines violence prevention standards.
-Inadequate assault/violence prevention training procedures and policies.
-Tacit acceptance of violence as part of the job (instead of a risk of the job).
-Inhospitable healing environments , inhospitable work environment.
-Dehumanizing environments.
-Intense emotions: pain, stress, witnessing others in their stressful experiences.
-Unsafe environments: Equipment, intrusions, loud noise, lack of egress in space design, isolation from others .

Privitera, M.R. Organizational Contributions to Healthcare Worker (HCW) Burnout and Workplace Violence (WPV) Overlap: Is This an Opportunity to Sustain Prevention of Both? *Health*, 8, 531-537. 2016 http://dx.doi.org/10.4236/health.2016.86056

Thank You

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