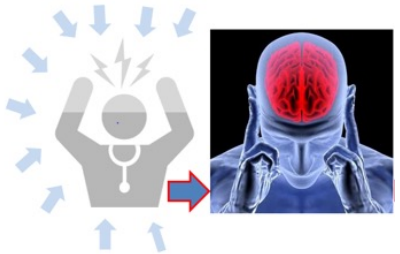
Organizational Contributions to Burnout and Workplace Violence



Charles E. Steinberg Lecture in Psychiatry and the Law.

February 1, 2023

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What is Workplace Violence?

1. **Any physical assault, threatening behavior, or verbal abuse occurring in the workplace.**
2. **Includes but is not limited to such events as 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 "Disruptive Behaviors": Behaviors that undermine a Culture of Safety, The Joint Commission Sentinel Event Alert July 2008

What is Burnout?

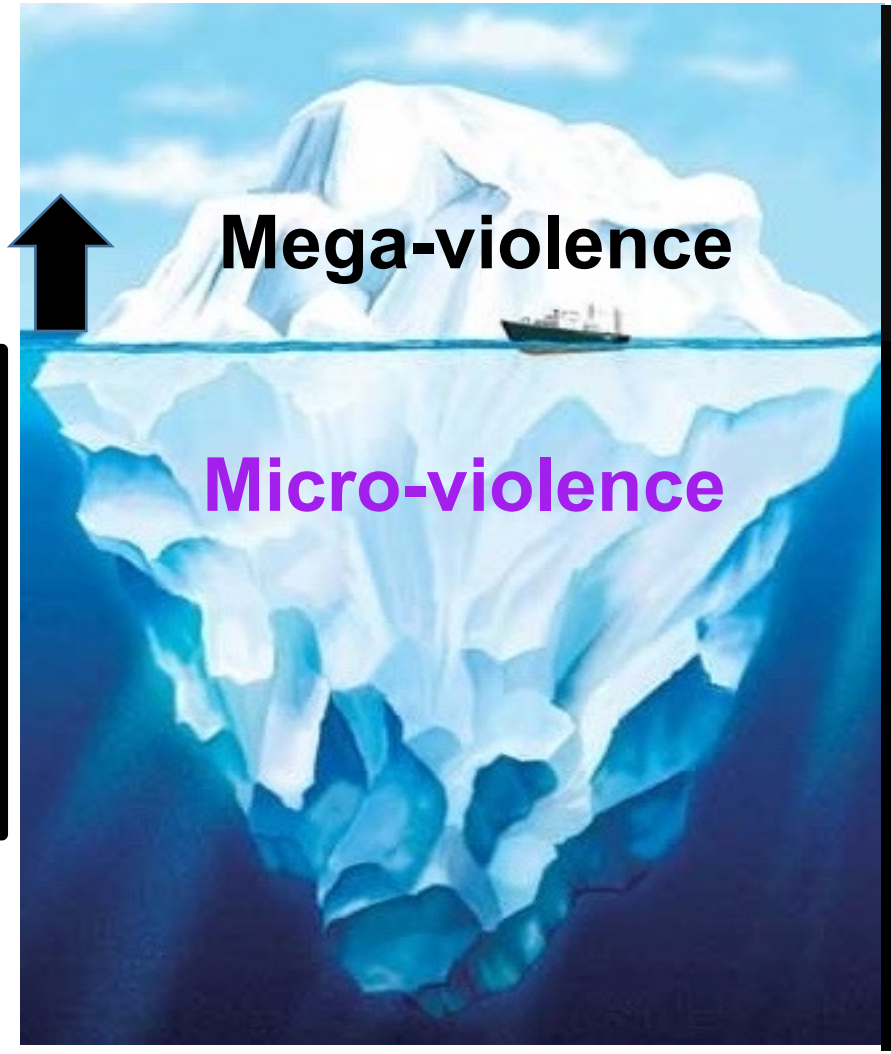
1. **Exhaustion:** Physical and Emotional. Downward spiral, **even after attempting to rest.**
2. **Depersonalization:** Dysfunctional coping mechanism. Keeping your patients at a distance to not drain you more: Cynicism, sarcasm, compassion fatigue- - nothing left to give.
3. **Lack of efficacy**: What is the use? What is the purpose? Work is subpar, feel like not making a difference, work has no purpose.

Maslach C, Schaufeli WB, Leiter MP. Job Burnout. Ann Rev Psychol 2001. 52: 397-422

Aggression/ Violence as Continuum

Law /society's common perception of violence:

Severe transgressions against individuals.



Mega-violence examples:

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

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 additive and cumulative.

Micro-violence examples:

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 w/o resources, 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]

Type I: Criminal intent-intrusive violence

Type II: Customer/client violence

Type III: Worker-on-worker violence

Type IV: Personal relationship violence

Bowie Expansion[2]

Type I: Criminal intent-intrusive violence

Type II: Customer/client 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.)

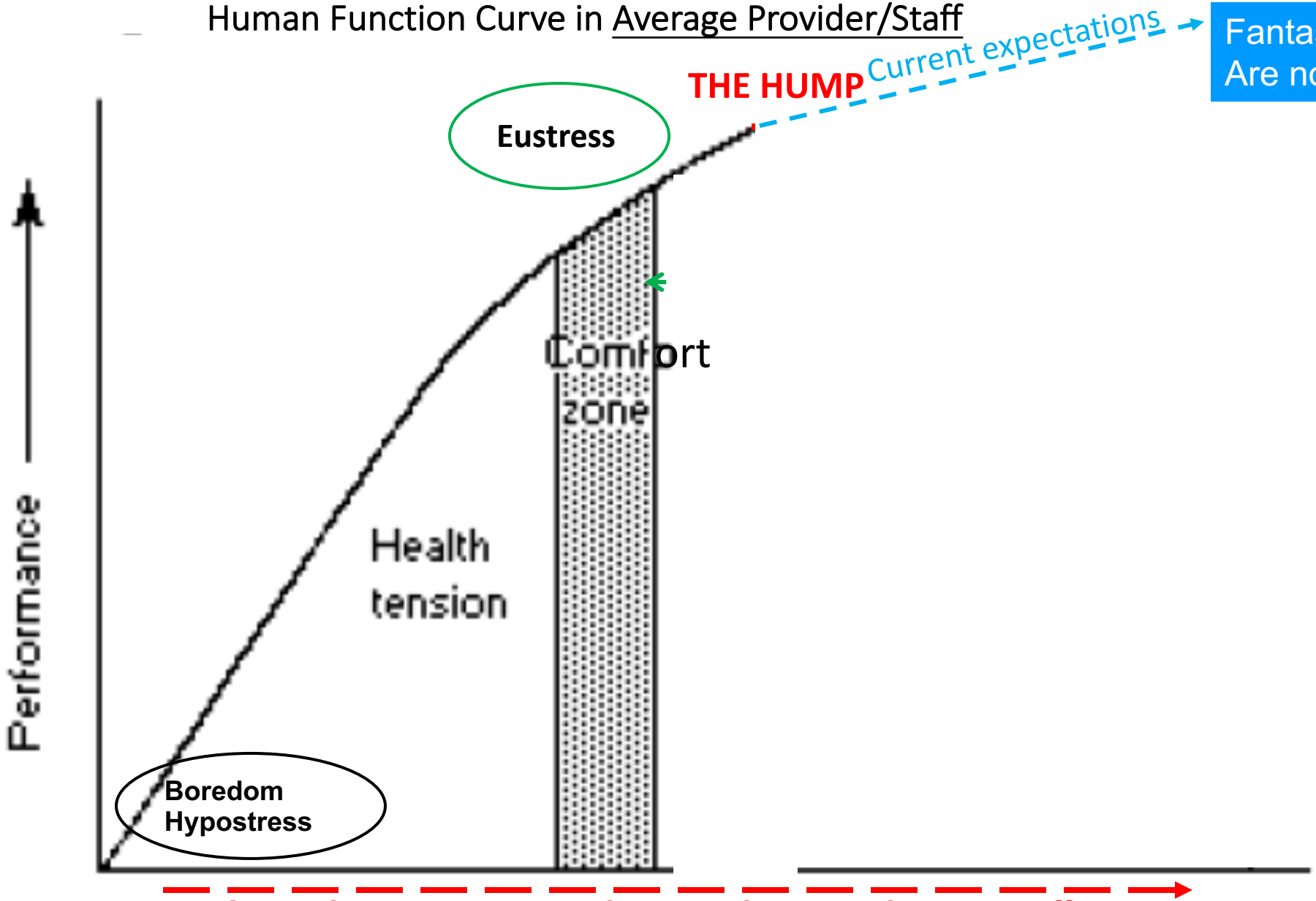
From: Parrinello K, Miller KD. Workplace Violence in the Healthcare Setting –An Administrative Perspective. In Privitera MR Workplace Violence in Mental and General Healthcare Settings. Jones and Bartlett Publishers ©2011 pp 59-71.

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.

- ***Occupational Stress:*** "the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources or needs of the worker".

National Institute for Occupational Safety and Health (NIOSH)

Human Function Curve in Average Provider/Staff



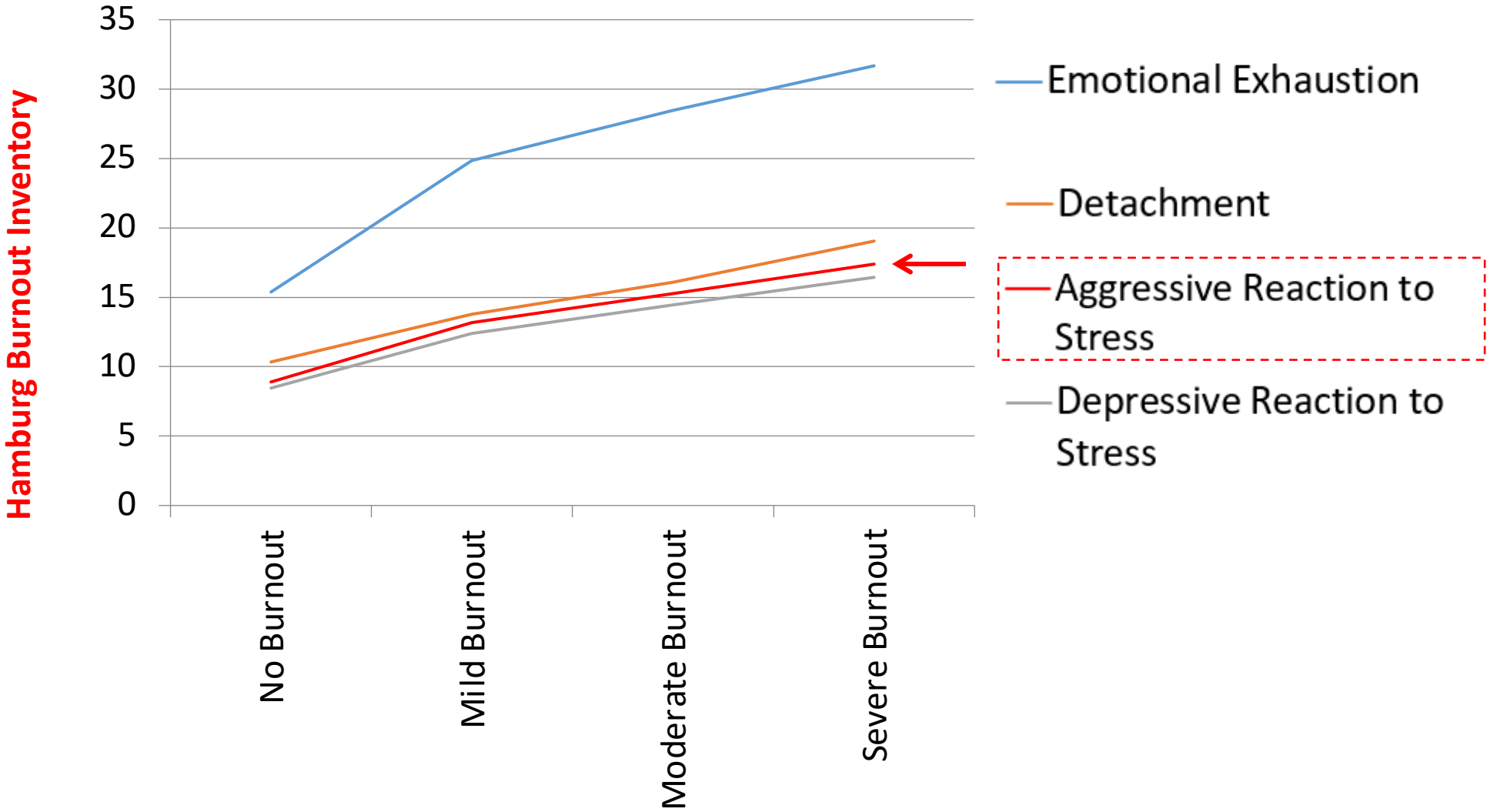
Intent of expectations: **Patients** as primary concern- patient safety movement.

Shareholders as primary concern- business of medicine requirements

Point A = even minimal arousal can precipitate breakdown

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

Depressive and Aggressive Reactions to Stress in Burnout (Dose-Related)



Adapted from: Wurm W, Vogel K, Holl A, Ebner C, Bayer D, Mörkl S, et al. (2016) Depression-Burnout Overlap in Physicians. PLoS ONE 11(3): e0149913.doi:10.1371/journal.pone.0149913

Workplace Stress:

Correlation with Reactions or Behaviors

Reactions/ Behaviors	Correlation
Frustration	.77*
Anger	.43*
Satisfaction	--.25*
Sabotage	.07
Interpersonal aggression	.17*
Hostility and complaints	.23*
Theft	.06
Substance abuse at work	--.09
Absenteeism	.05
Intention to quit	.30*

Chen PY, Spector PE. Relationships of work stressors
With aggression, withdrawal , theft and substance abuse.
Journal of Occupational and Organizational Psychology (1992) 65:177-184

Organizational/Systemic Issues in Medical Error, Burnout and

Errors: The Institute of Medicine (IOM) 1999 [1]:

Majority of errors are result of systemic /organizational factors, rather than substandard performance by individual healthcare workers.

Burnout[2,3,4]:

Majority of occupational stressors causing burnout are due to systemic/ organizational factors.

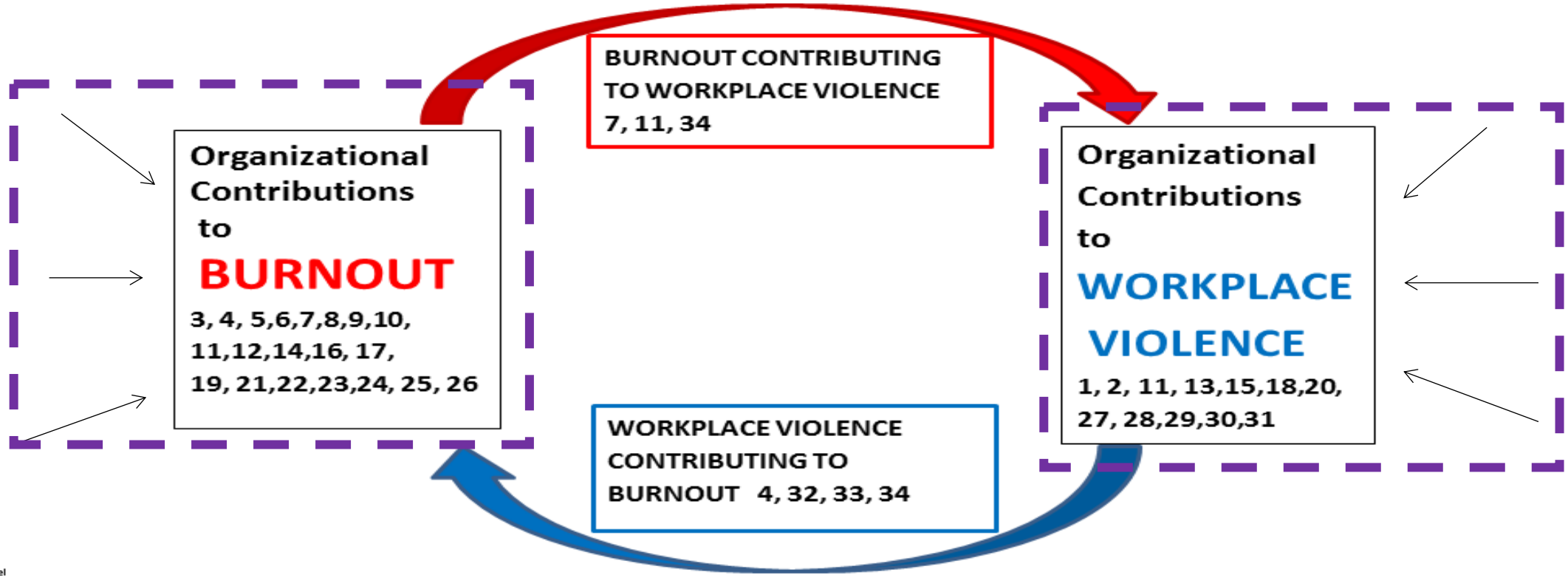
Workplace Violence (WPV)- Interaction of person, the stimulus and the systemic environment[5]

The Problem:

Majority of **interventions** for all three are directed at individual, and not at the system[5,6].

1. Kohn, L.T., Corrigan, J., Donaldson, M.S. , *To err is human: building a safer health system.* 2000, National Academy of Sciences: Washington, D.C
2. Friedberg, M.W., et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* RAND Corporation, 2013.
3. Sinsky, C., et al., *Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties.* Ann Intern Med, 2016. **165**(11): p. 753-760.
4. Privitera MR, Attalah F, Dowling F, et al. Physicians' Electronic Health Records Use at Home, Job Satisfaction, Job Stress and Burnout. Journal of Hospital Administration. Vol. 7(4) 52-59. 2018.
5. Bowie V Emerging awareness of the role organizational culture and management style can play on triggering workplace violence. In Privitera MR. Workplace Violence in General and Mental Hospitals. Jones and Bartlett Pub. 2010.
6. Sinsky CA, Privitera MR. Creating a "Manageable Cockpit" for Clinicians: A Shared Responsibility. JAMA IM. June 2018 Vol 178 (6): 741-2

Vicious Cycle Created by Perpetuating Forces



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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

Six Categories of Work Stress that can Contribute to Burnout

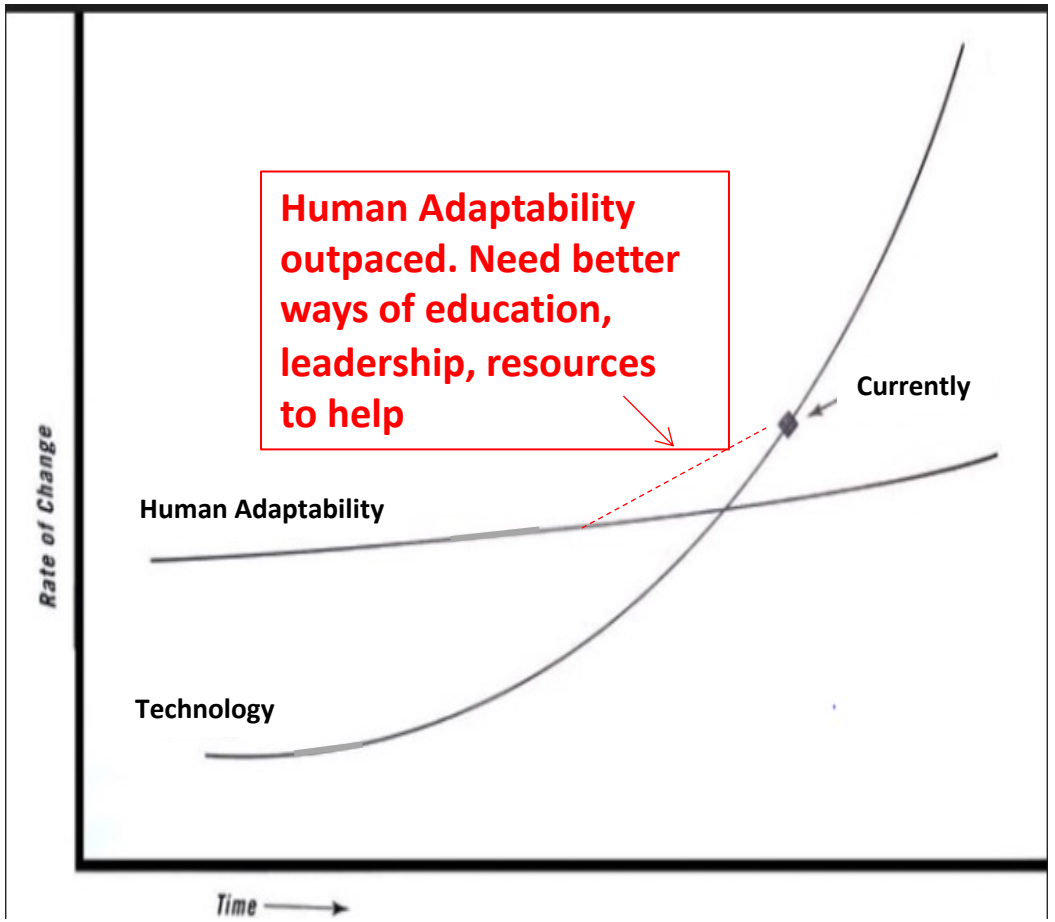
1. **Excessive workload**-physical, cognitive and emotional
2. **Lack of control**- being able to influence work environment
3. **Poor balance between effort and reward** -material and intangible rewards.
4. **Lack of community**- culture of mutual appreciation and teamwork
5. **Lack of fairness**- resources and justice
6. **Value conflict**- moral distress of having to participate in suboptimal, unethical circumstances.

Maslach C, Leiter MP. The Truth About Burnout: How Organizations Cause Personal Stress and What to Do About It. San Francisco, Calif: Jossey-Bass; 1997.

Technology Innovation Effect

- Increased connectivity, tracking, accountability, and expectations beyond work hours

- Tech costs low, personnel costs high….
  - ➢ "Disintermediation"= loss of intermediary staff who used to help.
  - ➢ Overhead cost shifts from corporation to consumers, patients, clinicians.
  - ➢ Spins off "shadow work" on remaining employees, often more tech 'solutions'.
  - ➢ Shadow work= "unpaid, unseen jobs that fill your day"



Surrounding culture:

- Group Think. Normalization of deviance.
- Dulls internal feedback that dangerous and unsustainable

*Adapted from Teller E. and Moore G. in Friedman T. Thank you for being Late. Farrar, Straus Giroux Publishers 2016
Lambert C. Shadow Work. The unpaid, unseen jobs that fill your day. Counterpoint. Berkley. 2015

From the book “Shadow Work” by Craig Lambert PhD:

- “…..for the most part, shadow workers **have no one to represent their interests or to push back** against the continual introduction of new shadow jobs.”

To consider:

- How do we address Shadow Work?
- Whose’ job is it to engineer its reduction?

→**Administration + Clinician Partnership**

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

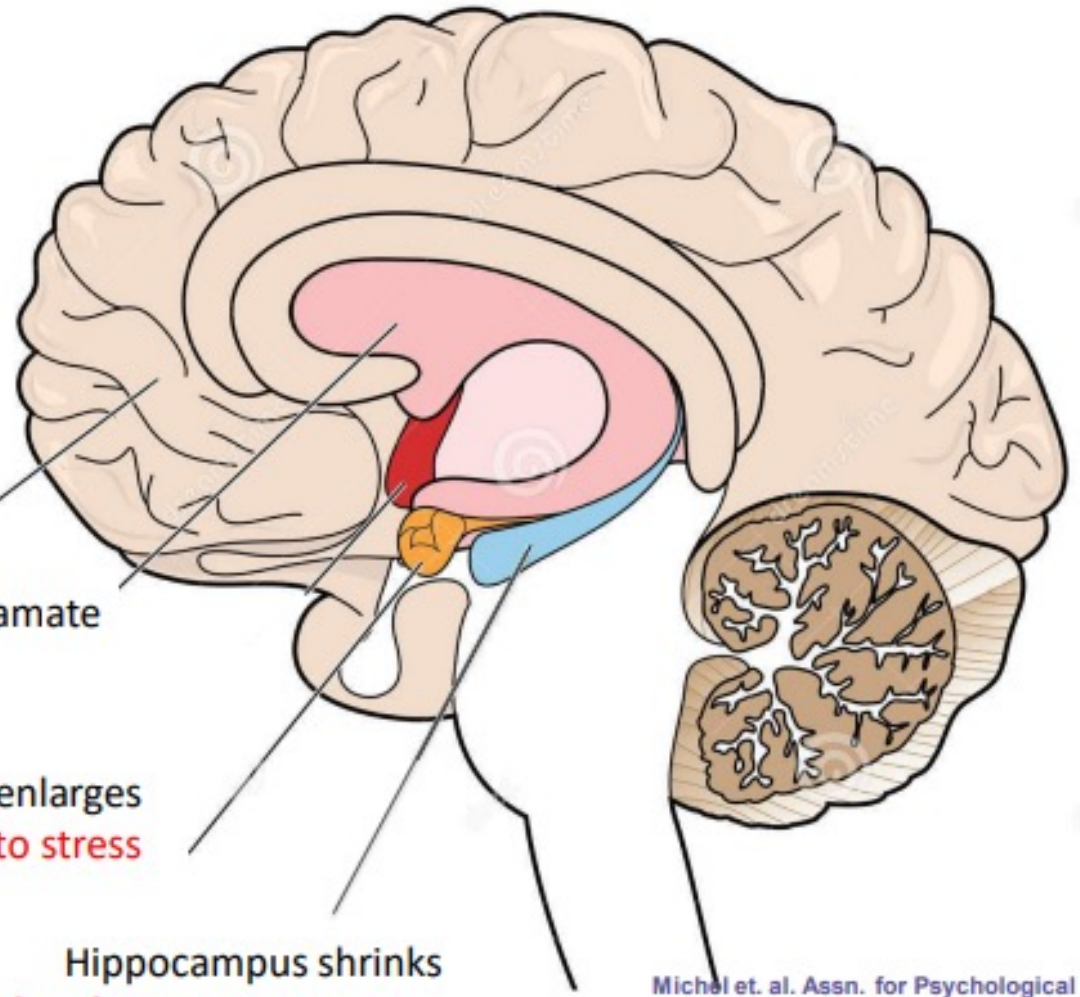
Spearman's rank correlation coefficient **0.628, P < 0.001***

Personal Effects

- Higher Suicide Rate among physicians- 400/yr.
- Major Depression
- Substance abuse
- Divorce
- Coronary Heart Disease:
  CHD 1.4 fold up to
  1.79 at high burnout levels
- Telomere shortening
  (hastened cellular aging)
- Brain changes… next slide
- Reduced career satisfaction
- Higher risk of being victim of patient-on-staff violence

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

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

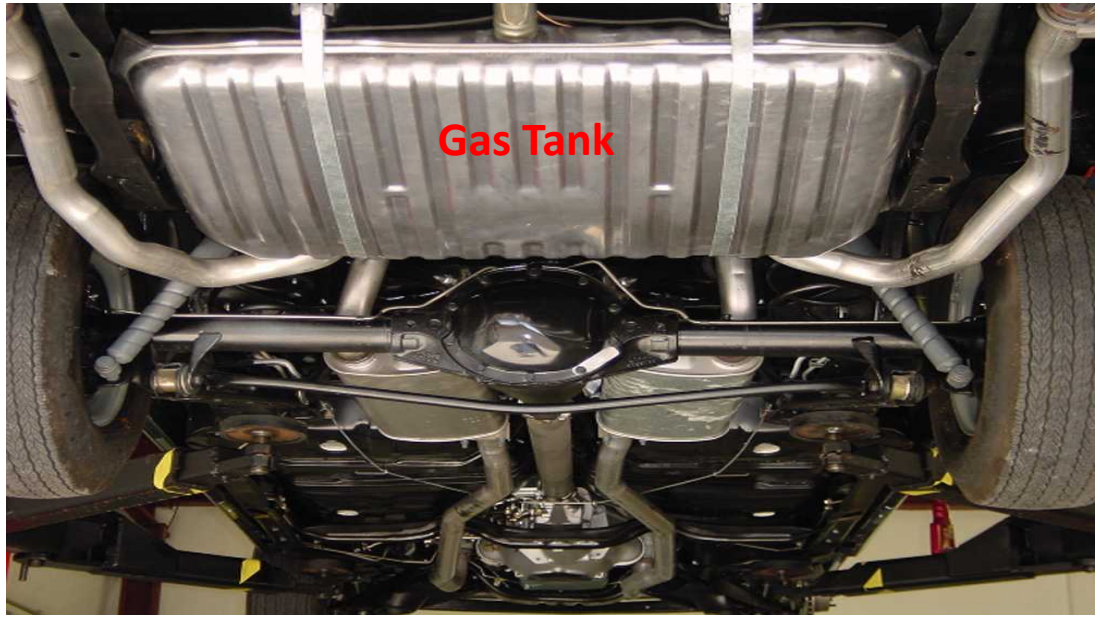
Amygdala enlarges
↑ reactivity to stress

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 Shaw T. 2022

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
Chronically burned out, stressed depressed, anxious, sleep deprived, overworked, underfed 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.

Partially Reversible Brain Changes

- Psychosocial stress affects **Limbic** and **Para limbic** networks:
  - Known with severe forms of stress- PTSD, child maltreatment
  - Also if **intense** **"everyday working" conditions over long periods of time, without recovery.**
  - **Key factor in brain injury is UNCONTROLLABLE STRESS.**
    - "Prefrontal cortex functioning is also impaired by uncontrollable stress exposure, including an acute stressor if the individual feels threatened by the situation. This scenario evokes a series of chemical events in the brain that rapidly disconnect PFC circuits" *.
- Many changes can be **reversible** after cessation of the stress →

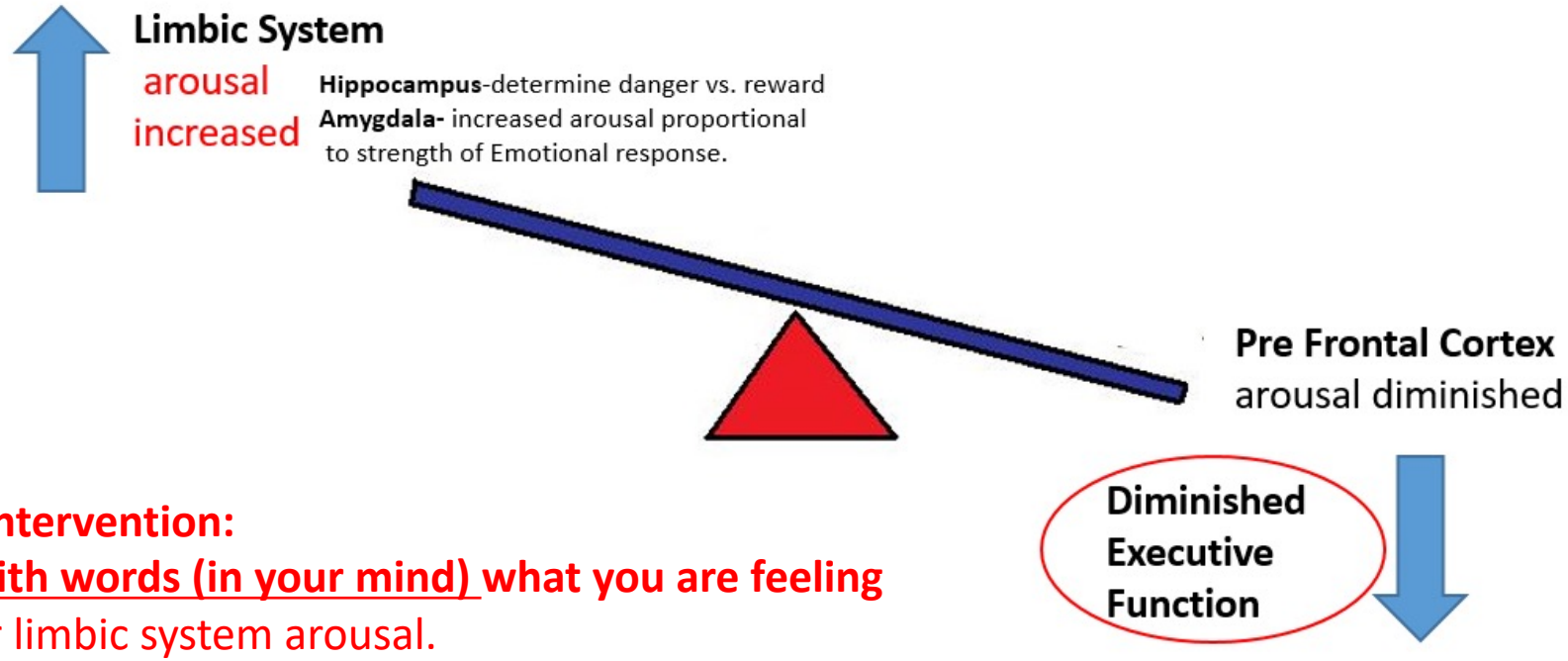
  Urgent interventions are needed

Savic I. Cerebral Cortex, March 2018;28: 894–906
*Arnsten A, Shanafelt T. Physician Stress and Burnout. The Neurobiological Perspective. Mayo Clinic Proceedings. March 2021;96(3):763-769

Chronic Uncontrollable Stress or Acute if Threat.=>

Perception of Threat to Wellbeing

- Cognitive overload, emotion work, other forms of overwork
- Frustration from over expectations
- Continued demands but not enough resources
- Chronic elevated Allostatic load #.



Personal Intervention:
****Label with words (in your mind) what you are feeling**
to lower limbic system arousal.

Allostatic load—wear and tear physiologically from chronic or repeated exposure to stress.

Executive Functions of the Brain

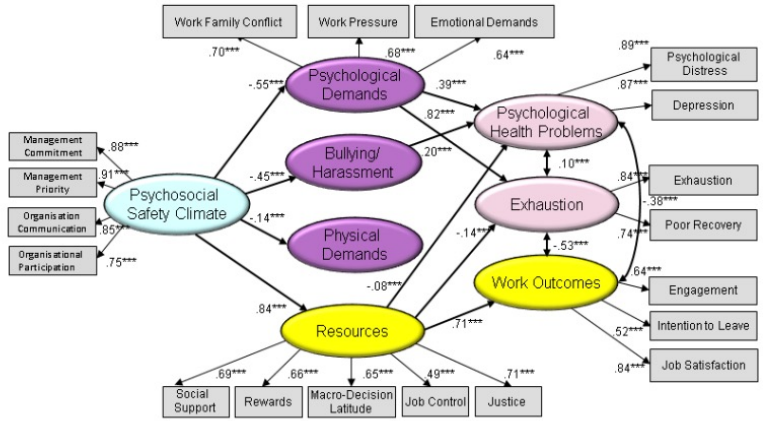
Pre Frontal Cortex

1. **Focus, Attention**
2. **Self Control of Behavior and Speech**
3. **Plan and Organize**
4. **Perspective Taking**
5. **Cognitive Flexibility**
6. **Medical and other Decision Making**
7. **Ability to Defer Gratification**
8. **Estimating Time**
9. **Working Memory**

Negative and Positive Concepts to Characterize Organization Environment—

1. What are underlying biological mechanisms? Words (jargon) may be failing us.
2. Is there a similar brain experience for "bullying", "uncontrolled stress", "mandates without resources to do them", "micro-aggressions"?

- **Toxic Work Environment**
  - Bullying, high stress, work overload (cognitive physical and emotional work), long workhours, lack of trust, lack of respect, micro-aggressions, micro-trauma, lack of supportive relationships to buffer.
- **Psychosocial Safety Climate-** Upstream determinant to conducive work environments, psychological health, work outcomes, engagement.

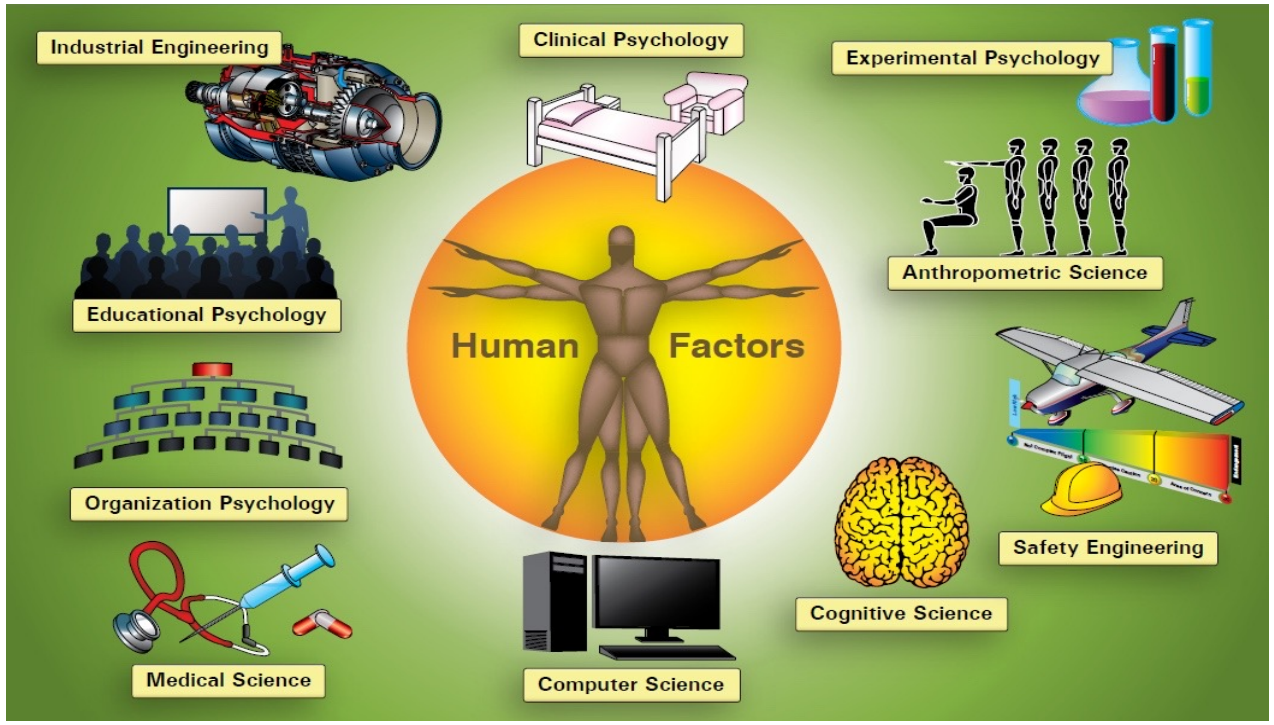


• Organizational Health

- **Organizational Alignment**
  - Cohesive leadership team aligned purpose, vision, mission, and priorities.
  - Straightforward strategy.
  - Communication plan to share that strategy throughout the organization.
- **A Focus on Employee Well-Being**
  - Cares about its employees, demonstrates that concern through policies to support the workforce
- **Commitment to Organizational Justice**
  - Ensure that all employees receive the same treatment: compensation, benefits, or promotions.
- **Clear Processes and Workflows**
  - Workflows are clear and communicated across the organization. As a result employees understand how the organization gets work done and makes decisions.
- **Opportunities for Professional Development**
  - Provides opportunities for employees to learn new skills and grow their careers based on their unique strengths and goals.
- **Purposeful Work**
  - Support employees in connecting their work to a larger purpose or set of values — in short, show people that what they do matters.

https://www.safeworkaustralia.gov.au/system/files/documents/1702/the-australian-workplace-barometer-report.pdf

Human Factors / Ergonomics (HFE)



Definition:
The scientific discipline that draws from multiple sciences to understand and optimize interactions between **humans** and other **elements of a work system**.

Goal: Optimize worker well-being *and* overall system performance.

- **Patient safety** is a component of system performance.

International Ergonomics Association www.iea.cc

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

Human Factors influence on healthcare workers
Phases of awareness and action…….

"I'm right there in the room and no one even sees me."

"I'm right there in the room and no one acknowledges me.
Some just don't know how to deal with me."

Glad you are dealing with me now.
I'm massive.

Increasing awareness and action

Adapted from

Some Reasons for Invisibility

Non familiarity with Human Factors/ Ergonomics

Authority effect- We do what national state or industry authorities tell us to do.

Financial measures frequently change

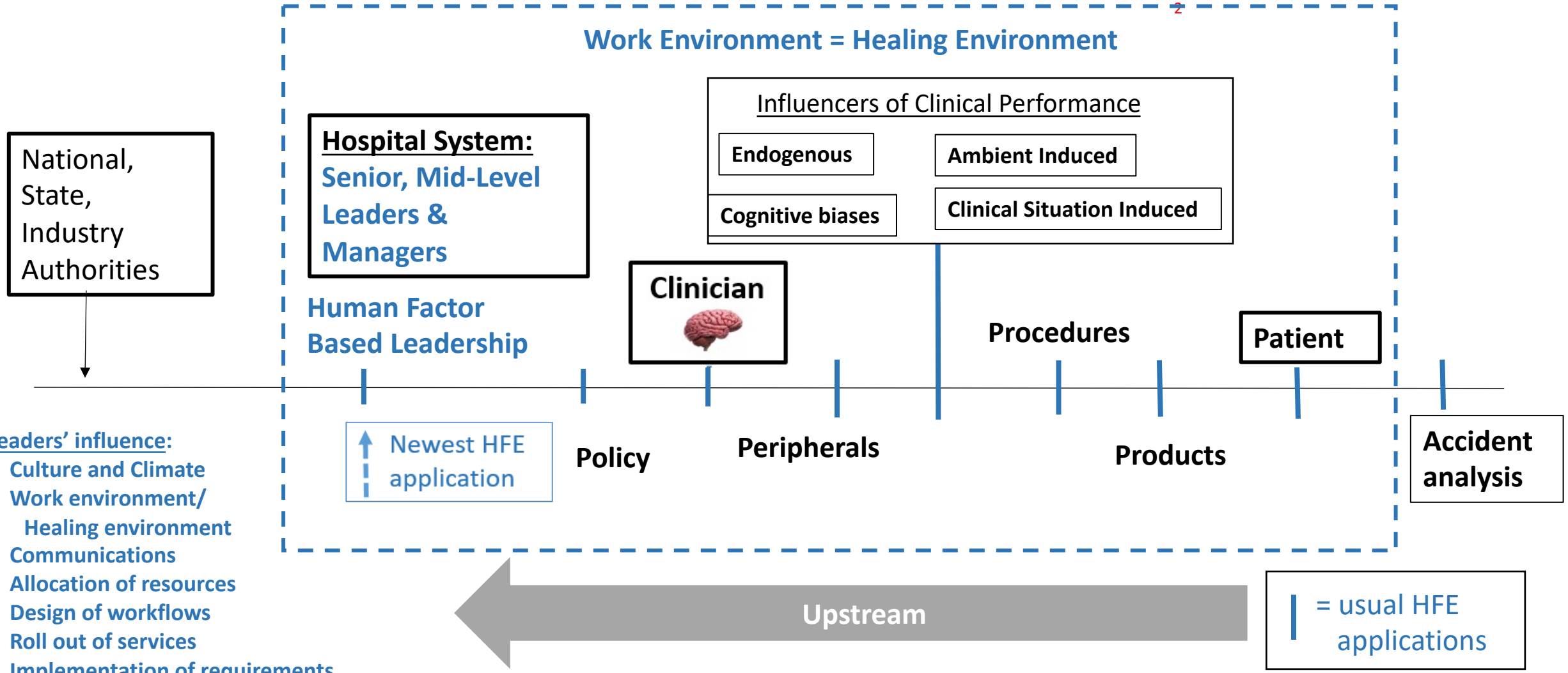
- Surge of metrics and mandatories
- "Pay for Performance"- requires "quality", "value" or "safety" measures.
- Consumes leadership attention

Costs silos—obscures how costs relate to each other

Halo bias-

- Assigning the term "quality" or "patient safety" to a process may reduce questioning the science behind it.
- Assumption: Must be good since termed "quality" or "safety" metrics
- Logic becomes circular and self-perpetuating- despite accumulated total harm.

Human Factors/ Ergonomics (HFE)
Spectrum of Applications in Healthcare



External
Requirements, Laws, Mandates, Regulations

Basic Knowledge about Burnout and Cognitive Load

"Keep lights on" **C- Suite and other Senior leadership** *"Must comply to survive"*

Administrative Offices

Quality & safety | Finance | Compliance | Risk Management | Billing | Health Info Management |
Educational Mandatories | Medical Staff Office

Administrative offices: Collaborate, coordinate, simplify, harmonize, satisfice to be concise.
Keep track of total mandatory requirement burden.
Provide time to achieve compliance while at work.

- **More brain power for better work performance.**
- **Improved work satisfaction.**
- **Message: Leadership cares about staff wellbeing.**

Taking care of patients

Taking care of patients

Cognition Types:
Cognition can be Automatic or Controlled Thought

Automatic Thought

Habit Memory

also called **System 1 Thinking**

Quick stimulus → response

Utilizes far less neural resource (glucose)

Shifted to when cognitive resources are low.

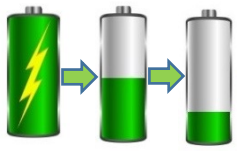
Controlled Thought

Executive Function, Cognitive Flexible Memory

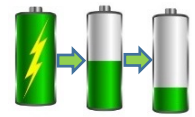
also called **System 2 Thinking**

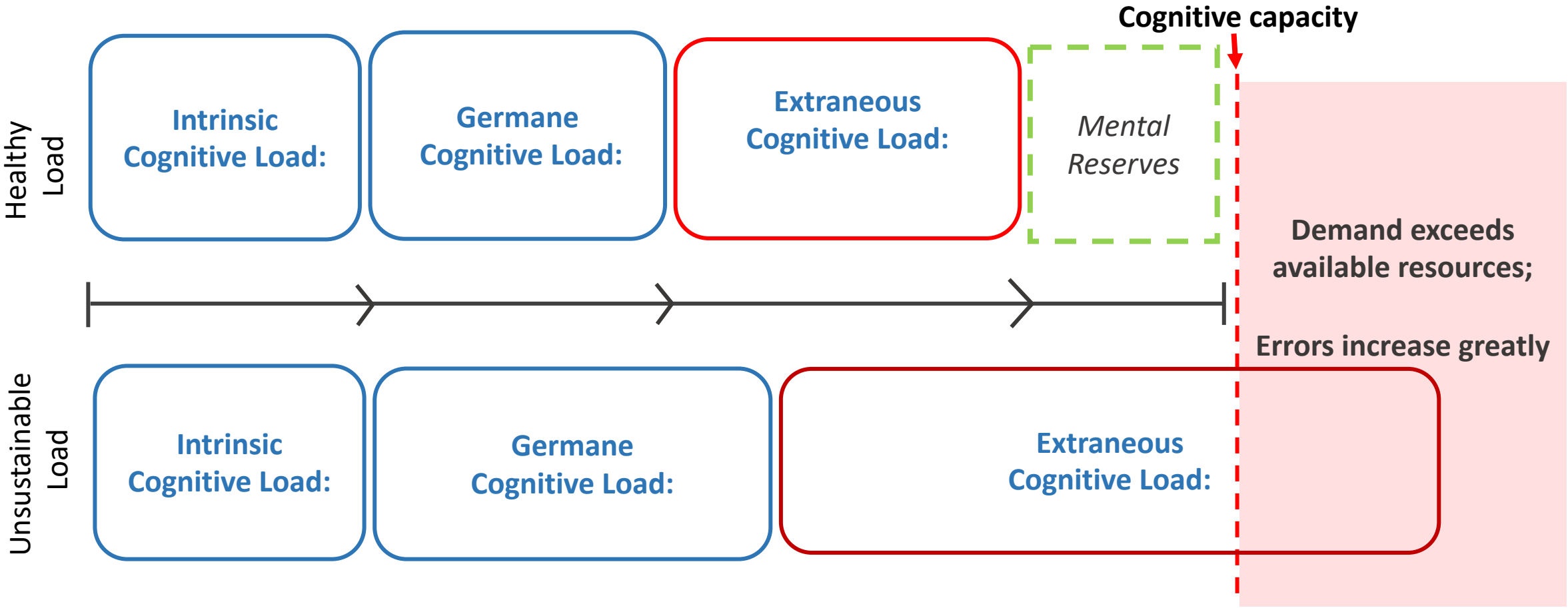
Used when carefully thinking through differential diagnosis, weighing pros or cons of a plan of treatment, etc.

Limited resource, high utilization of neural resource (glucose).



Controlled Thought is a Finite Resource



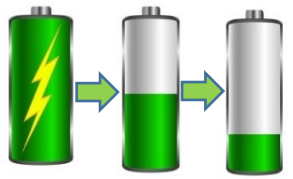


Once capacity reached…… brain is depleted of resources required for Controlled Thought.
Then….. Automatic Thought, Load Shedding and Goal Shielding occur.

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

Controlled Thought- Used Up in These Processes

Budget These Carefully

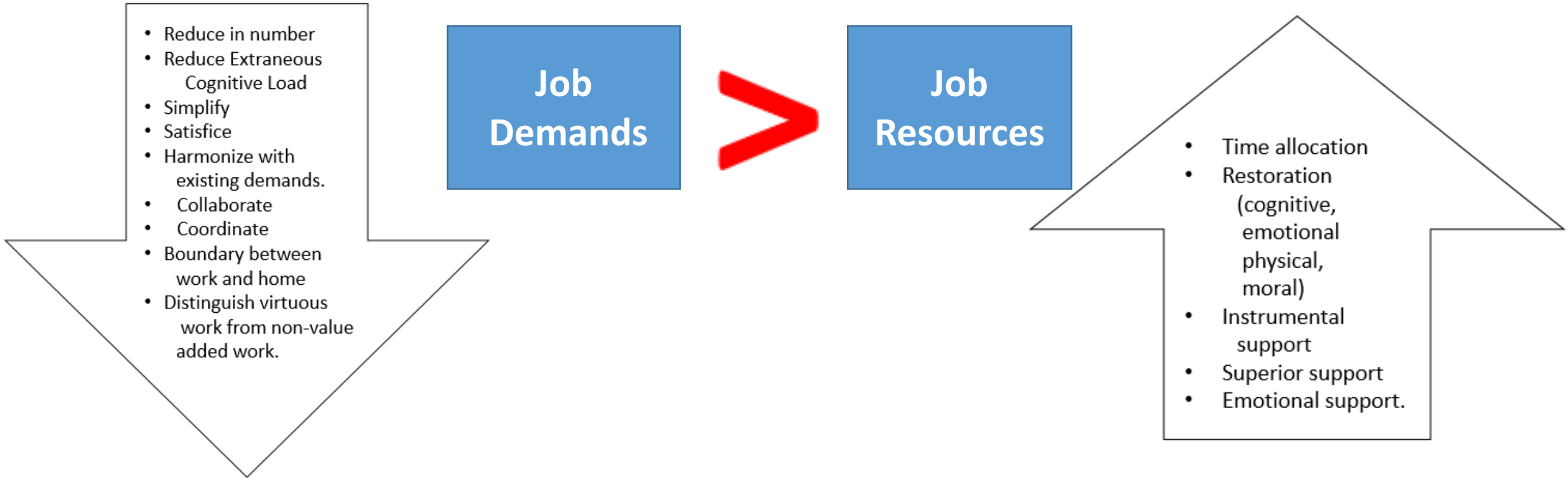


- Focusing of attention
- Decision making (no matter the size of decision)- ***EMR clicks matter***
- Sorting, classifying- ***Device layout, where to routinely find information matters.***
- Multitasking (shifting attention between topics)
- Getting back on track after interruption. ***Best Practice Alerts (BPA) usage matters***
- Maintenance of goals
- Maintenance of information active in working memory- ***Time/space between information and executing action on the information matters.***
- Updating working memory
- Self-regulation: Professionalism, self-effacement despite how treated,

  Maintaining "Aequinimitas" in setting of bleeding, injury, pain, etc.
- Emotion work: Dealing with bad outcomes, distressed patients and families

Demand-Resource Model

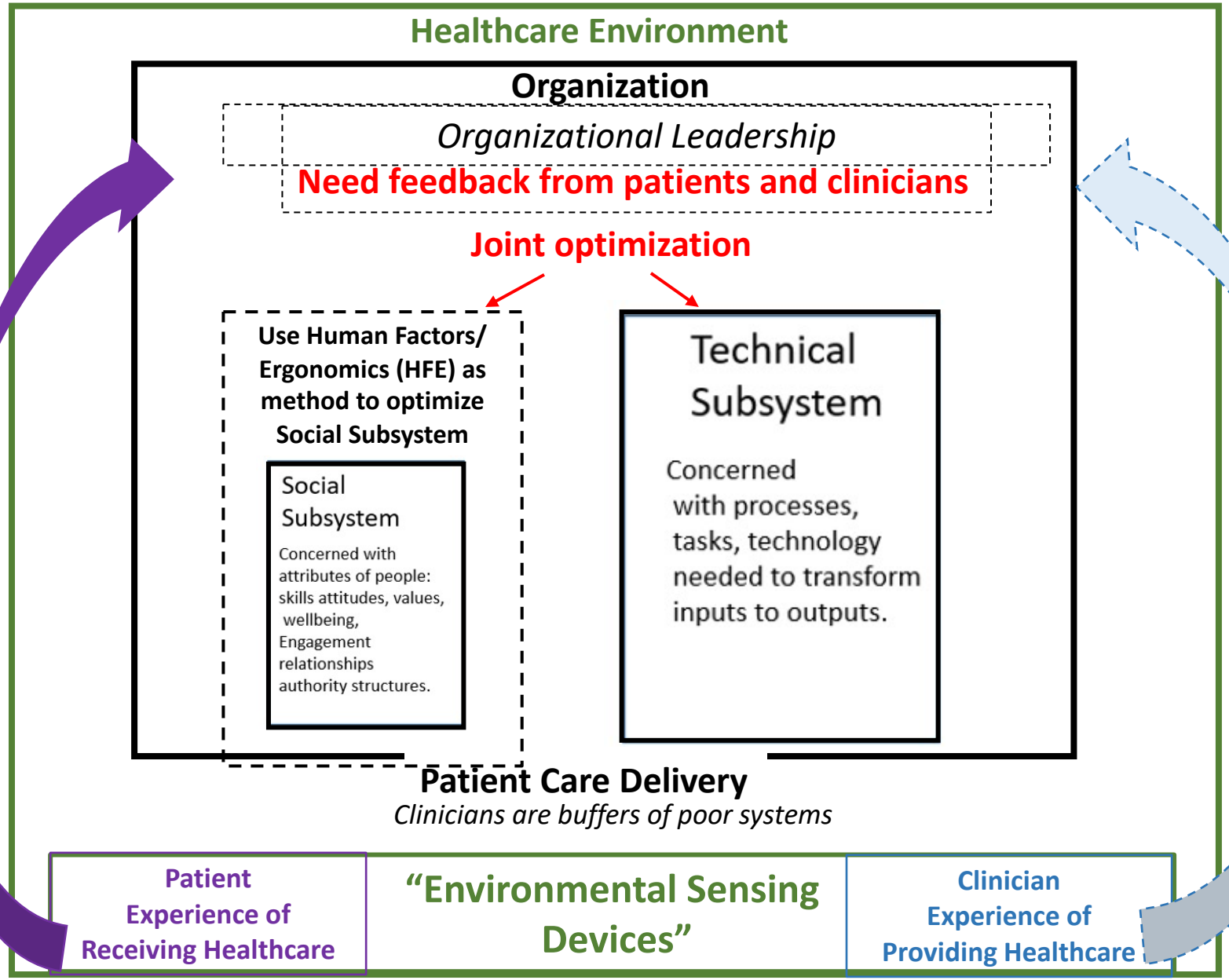
Burnout



Based upon Demerouti 2001

Designing Effective Organizations: Sociotechnical System (STS) Perspective

Patient Experience feedback to Organizational Leadership Currently exists



Clinician Experience feedback to Organizational Leadership: *Needed but not yet developed*

-No metrics exist immediately tied to financial survival.

-Medical Culture of Endurance and Silence impairs feedback.

-Hierarchy and gatekeeping impairs feedback.

-Reduced awareness and acknowledgement of overwhelm impairs feedback.

Pasmore WA. Designing Effective Organizations. The Sociotechnical Systems Perspective. John Wiley & Sons. New York. 1988

Pasmore W, Winby S et al. Reflections: Sociotechnical Systems Design and Organization Change, Journal of Change Management, 19:2, 67-85. 2019

Factors associated with burnout among health workers

In 2022 Five National/International Reports came out emphasizing the critical need to help **HCW Burnout.**

1. The Surgeon General's advisory **Addressing HCW Burnout**

May 2022

2. The NAM **National Plan for HC Workforce Wellbeing**

Oct 2022

3. The AHA's report: **Strengthening the HC Workforce**


June 2022

4. SAMHSA's **Addressing Burnout in the Behavioral Health Workforce through Organizational Strategies**


Sept 2022

5. The Qatar Foundation/World Innovation Summit for Health (endorsed by WHO): **Our Duty of Care**


Oct 2022

Nationally- on to the problem! Forward thinking of the new CEO.

The Joint Commission announces major standards reduction and freezes hospital accreditation fees to provide relief to healthcare organizations

Fourteen percent of standards eliminated across accreditation programs
Wednesday, December 21 2022

Media Contact:
Maureen Lyons
Corporate Communications
(630) 792-5171
mlyons@jointcommission.org

(OAKBROOK TERRACE, Illinois, December 21, 2022) – The Joint Commission today announced it is eliminating 168 standards (14%) and revising 14 other standards across its accreditation programs to streamline requirements and make them as efficient and impactful on patient safety, quality and equity as possible.

News & Multimedia

- The Joint Commission Stands for Racial Justice and Equity
- Blogs +
- Joint Commission Saves Lives +
- Events
- Fact Sheets
- Newsletters
- News Releases
- Podcasts
- Speakers Bureau
- Video Resources

Legal issues: Workplace responsibility to reduce burnout, emotional harm, high 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 :*

Corporate Responsibility for Systemic Occupational Stress Prevention

R. Kasperczyk
School of Business and Law, Victoria University
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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

FINDLAW / LEARN ABOUT THE LAW / ACCIDENTS AND INJURIES / TORTS AND PERSONAL

Suing for Emotional Distress at Work

Can I File a Workers Comp Claim for Burnout?

November 21, 2022 By James Hoffmann

Burned-out employees are 23% more likely to visit the emergency room.

RESOLUTION

Calling upon the Occupational Safety and Health Administration to recognize Secondary Traumatic Stress as a workplace hazard, recommend steps to address mental health injury as a psychological hazard in the workplace as they do with physical injury, and create a standard for Secondary Traumatic Stress.

RESOLVED, BY THE COUNCIL OF THE CITY OF PHILADELPHIA, That this Council calls upon the Occupational Safety and Health Administration to recognize Secondary Traumatic Stress as a workplace hazard, recommend steps to address mental health injury as a psychological hazard in the workplace as they do with physical injury, and create a standard for Secondary Traumatic Stress.

FURTHER RESOLVED, That a copy of this Resolution be transmitted to the Occupational Safety and Health Administration as evidence of the sentiments of this legislative body.

Introduced by:

Councilman Derek S. Green

December 5, 2019

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Home | Blog | Baker and Gilchrist News | Health Care System Causing Dangerous Burnout Among Doctors and Nurses

Health Care System Causing Dangerous Burnout Among Doctors and Nurses

15 JAN

Posted by Baker & Gilchrist in Baker and Gilchrist News

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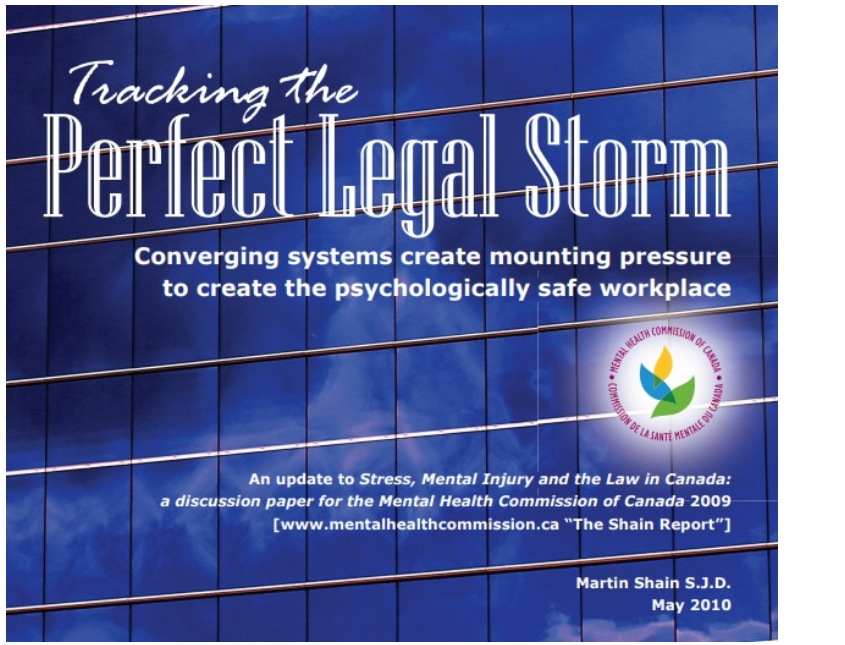
Archives

GET YOUR FREE CASE REVIEW TODAY

ONLINE NOW



Summary of New Material

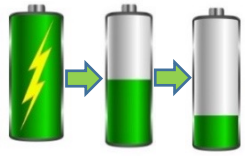
1. **Common mechanisms from organizational impact affecting Burnout, Error and WPV**

2. **<u>Danger</u> of excessive (well-meaning) expectations- accumulating from multiple sources.**

3. **Total Workload= cognitive, emotional and physical. Assign support resources accordingly.**

4. **Be aware of and reduce <u>"shadow work"</u>.**

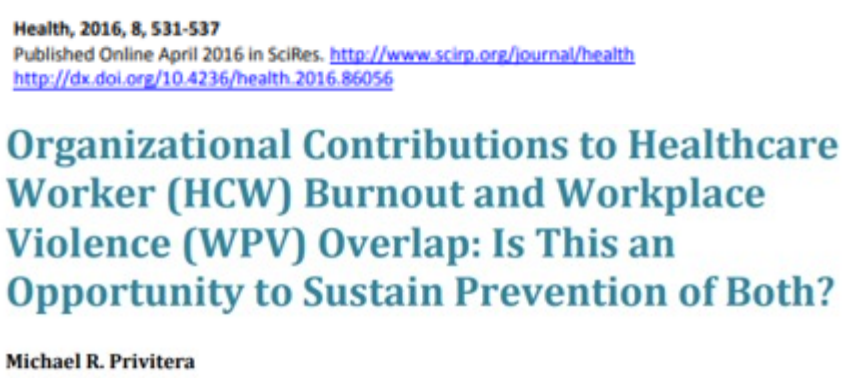
5. **Highly trained clinician cognition is a <u>limited resource</u>**



6. **<u>Firmly preserve Time Off</u>: Human needs / restoration / boundary between work and home.**
   - **→Need policy & culture supportive.**
   - **→Must find way to get all requirements of the job done at work.**

Thank you !

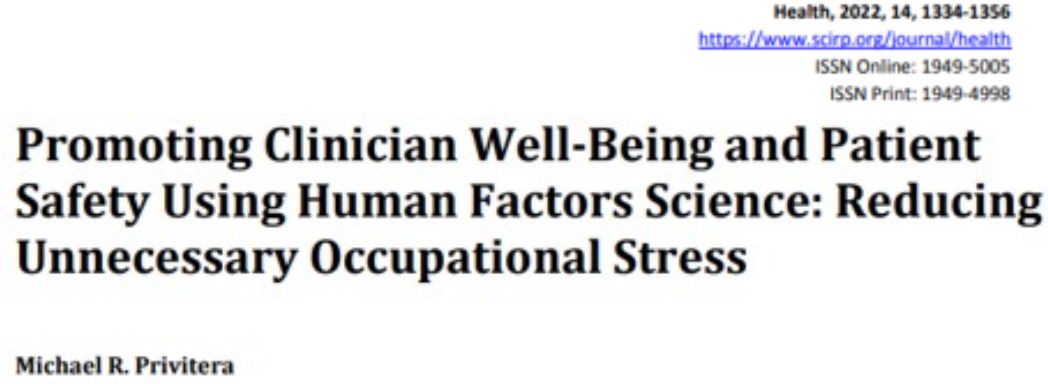
Discussion



Health, 2016, 8, 531-537
Published Online April 2016 in SciRes. http://www.scirp.org/journal/health
http://dx.doi.org/10.4236/health.2016.86056

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

Michael R. Privitera



Health, 2022, 14, 1334-1356
https://www.scirp.org/journal/health
ISSN Online: 1949-5005
ISSN Print: 1949-4998

Promoting Clinician Well-Being and Patient Safety Using Human Factors Science: Reducing Unnecessary Occupational Stress

Michael R. Privitera

Website: www.MichaelRPriviteraMD.com

E-mail: Michael_Privitera@urmc.Rochester.edu

Reserve Slides Follow

Table 4. Broad stroke interventions to reduce Extraneous Cognitive Load (ECL).

Engage Administrative offices of Risk Management, Patient Safety and Quality, Medical Staff Office, Compliance, Wellness, Human Resources, Medical Executive Committee and Communication Office to keep all aware of processes.
1. Evaluate processes, polices and metrics currently in place
Are they strategic (why)?
Are they necessary (why)?
What might be the unintended consequences? (Note: administrative leadership would make more informed decisions if they have foundational knowledge of multiple are of impact of burnout)
In the context of meeting requirements, is there a better way to not drain highly trained clinician time and brain (neural) resource?
Understand clearly what a regulatory requirement specifies. Look up the written requirement.
Satisfice-satisfactory and sufficient to meet the requirement but no locally added extras.
Can make additional information available for voluntary education or for use to be called up for use in future relevant clinical situations as a clinical resource.
Create a clearing house for all mandatory requirements that senior leadership be made aware of and a mechanism to manage the total mandatory load on clinicians espoused by multiple administrative offices.
Job-Resource model of burnout [55]. When cognitive jobs go up, resources need to also go up to avoid burnout and error. Job-related requirements must be a cost of doing business for the organization. This creates a business-related force to be most efficient and time conscious of clinician time as to what must be mandatory and what can be voluntary.

2. Standardization

What are the core operational processes to standardize and promote routines? When should you allow and encourage aligned autonomy or customization?

Are there opportunities to standardize and simplify layout locations of core functions of care of patients throughout the institution?

Can clinical unit design be standardized (with collaboration of clinicians with architects) to make easier to find what is needed easily regardless of unit worked?

Consider when standardization might jeopardize safety or not meet a patient's unique needs.

Are there options for "wiggle room" built in?

Decision to engage most' wiggle room" options should be under the control of the clinician, but consider when variation might require the authorization of a superior.

3. Consolidate information

Reduce split attention effect. Separated information requires more brain (neural) resource to cognitively process than physically integrated information.

Be user-centric-design groupings of information by what works best for the user.

Keep wording to key information so it can be processed by working memory. Finer detail can be pursued by interest or wish to understand more fully after essentials are understood.

Process Coupling. Workflow processes related to each other should be made physically closer together for ease and simplicity of operations.

4. Decrease redundancy. Redundancies are extra elements not absolutely necessary for understanding or functioning.

In communication of data and design. Irrelevant information clogs up the working memory which transfers information to long term memory. Hence clogging may contribute to forgetting.

Be concise

Be precise

Use emphasis strategically

5. Prioritize design

Equipment and layouts should have deliberate designs that consider human limitations.

Anticipate situations of clinician low cognitive resources, such as occur in burnout, high stress, high volume demand, evening or night shift, extended work hours, sleep and food deprivation.

Over-complexity in design will require high cognitive resources. Keep in mind the competing factors for clinician's attention and potential cognitive processing state affected by situations of low cognitive resource.

6. Leadership Collaboration

Among all leaders who roll out requirements and work expectations

Collaboration with clinicians, encouraging participatory management, input from those most familiar with the work to be done.

Understand how work-as-imagined compares to total real work done.

Be aware of shadow work (work off metrics, unseen, unpaid but fill the day) and Work Outside of Work (WOW).

Find opportunities to lower total institutional Extraneous Cognitive Load (ECL) by means of the multi-administrative office collaboration.

Work with Human Factors/Ergonomics professionals. Hire them at your institution.

Consider collaboration of HFE professionals with Lean professionals, as HFE science will help both prevent future and mitigate existing risk areas. HFE "waste" to be reduced or eliminated is predominantly ECL. Lean processes are well known in hospitals and can be harnessed to achieve reduction of ECL burden.

Job-resource model of burnout [55]. Table adapted and expanded from [10].

World Health Organization Violence Typology

FIGURE 1

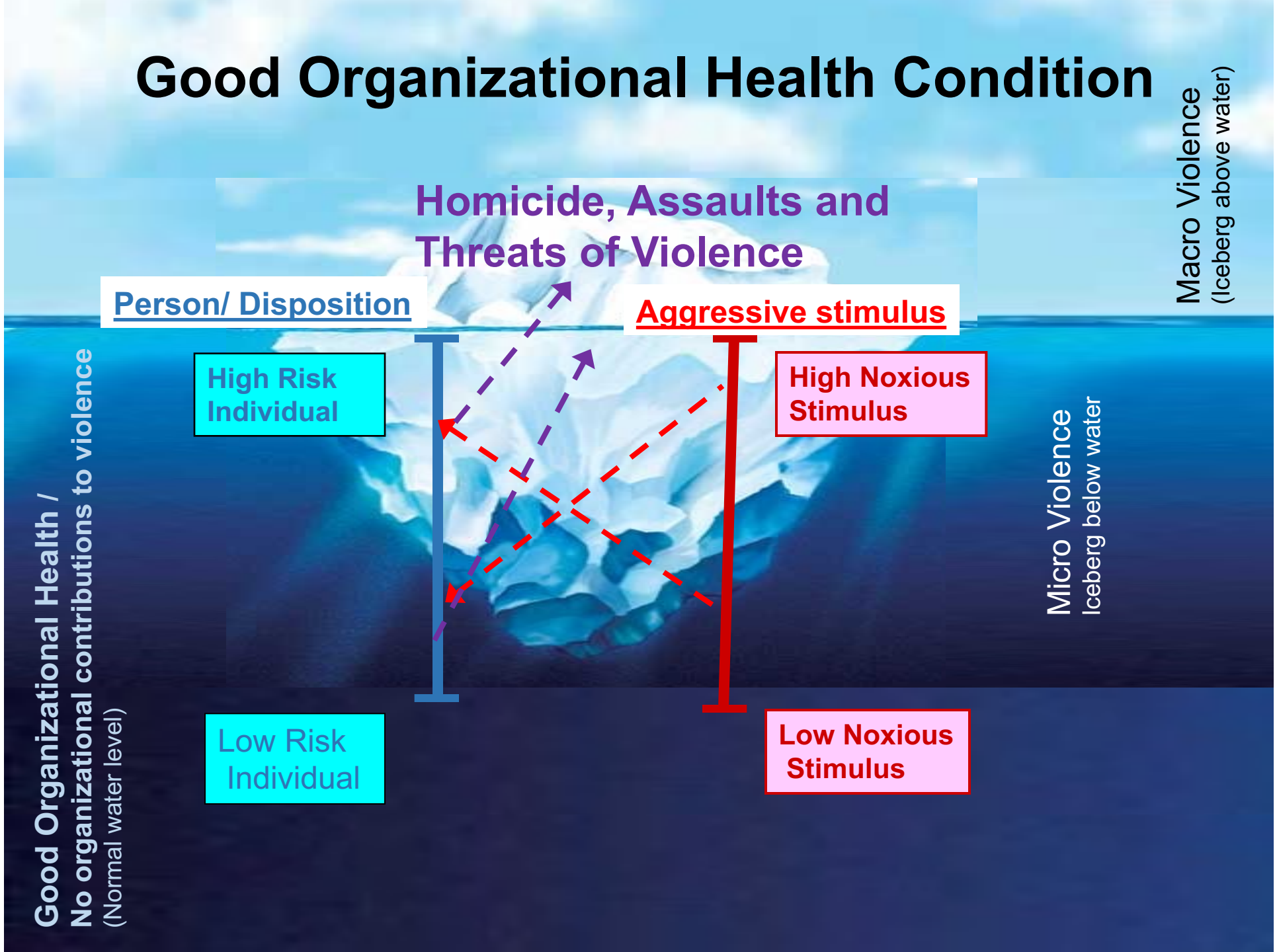
A typology of violence

Economic

Attacks by larger groups motivated by economic gain.

i. Disrupting economic activity
ii. Denying access to essential services
iii. Creating economic division and fragmentation

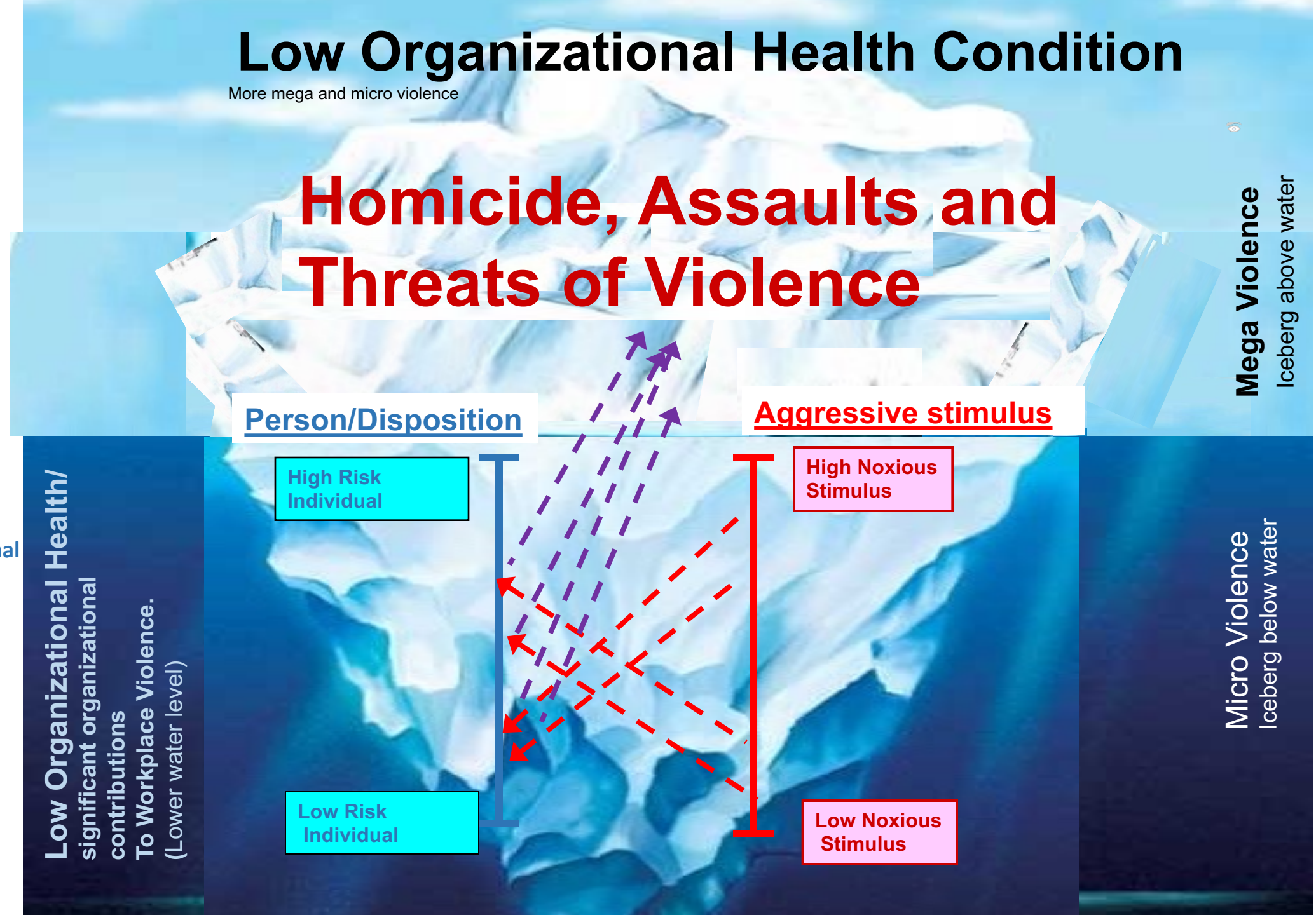
Water=
Organizational Health



Low Organizational Health Condition

More mega and micro violence

Homicide, Assaults and Threats of Violence



Water=
Organizational Health

Introduction to Shadow Work: "Unseen, unpaid jobs that fill your day"

View from healthcare decision-makers

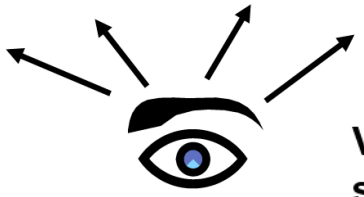
Prescribed work

1. Office Start up → 2.W arm up computer Software booting EMR booting → 3.Patient Arrive On time, right location → 4.Financial Pre-meeting → 5.Waiting Room receptionists Clinical based forms given to patient → 6. Nursing VS taken and documented → 7.EMR record review preparation →

Shadow Work

8.Patient Interview/ Evaluation/ Procedures → 9.Writing Orders and Labs → 10.Writing Notes and Diagnosis Billing

Shadow Work



View from clinician seeing patients

Prescribed work + Shadow work= Real work

Adapted from Lambert C. Shadow Work: The unpaid Unseen jobs that fill your day. Counterpoint Press 2015

Shadow Work: A Real Practice… Just Not All At Same Time.

View from healthcare decision-makers

Prescribed Work

1. Office Start up

2. Warm up computer Software booting EMR booting

3. Patient Arrive On time, right location

4. Financial Pre-meeting

5. Waiting Room receptionists Clinical based forms given to patient

6. Nursing vs taken and documented

7. EMR record review preparation

Shadow Work

Office environment
- Temperature too warm, too cold
- Window crack- draft,
- Noise outside Grass cutting and trimming

- New EMR security restrictions longer warm up
- Password expired, think of new one
- New EMR software roll out, need to learn it to operate EMR.
- Software not working, need time on phone with IT support.

- Intro letter to patient has wrong clinic address.

Changing support staff not know the clinicians . EMR software not link correct letter with correct clinic .

…….Delays

- Patient insurance letter not tailored to patient's insurance. Too much information. Patient confused, not bring correct information with them for financial counselor

……..Delays

- Pre-visit clinical rating scales were not given to patient to fill out, Substitute secretary, not familiar with customized EMR screen interface for this clinic.

- Different budget line clinics co-located physically, each has different EMR interface.
- Substitute nurses not think allowed to help on clinic.
- Vital Signs not obtained before visit

- Old records received but clinician cannot find them in EMR. Scanned into EMR under a non-intuitive file tab name coined by EMR vendor. Health Information Management (HIM) support staff use this file tab regularly, They are familiar with tab but clinicians are not.

Have to call Health Information Management (HIM) to find info if time.

Prescribed Work

8. Patient Interview/ Evaluation/ Procedures

9. Writing Orders and Labs

10. Writing Notes and Diagnosis Billing

Shadow Work= unnecessary (extraneous) cognitive load on clinician

Shadow Work

- Meaningful Use (MU) criteria must be met regardless of reason for visit.
- Smoking cessation
- Send for old records
- Pain score
- Multiple screening questions

Well meaning but creates competing mental demands. Require more mental effort to re- focus on why the patient is here.

Ordering a drug level: EMR build requires exact drug spelling and singular name. No drug synonyms allowed . Must hunt, trial and error to find out what works.

E.g.: Want Depakote level.

[Depakote= divalproex sodium = sodium valproate + Valproic acid]

- Cannot type in "Depakote" level, "divalproex sodium" level, or "sodium valproate"
- **Only "Valproic acid" recognized**.

- Ordering controlled substance: State requires checking a data base before allowed to prescribe,
- Password expired without warning.
- While patient is with you, must create complex new password, never used within the last 50 passwords.

Do not make mistake! (despite competing mental demands).

- Each clinic template is budget line driven.
- Template operation to get to next field *not consistent*: F2 to next section: can be ***, a write in , multiple choice drop downs, or single choice drop down.
- More documentation expected by local Compliance Office for "abundance of caution" to meet requirement (Compliance Creep").

View from clinician seeing patients

- Voice recognition software not working. [If call for support I will be on phone loosing time to do work]. Chose to type without it.
- "Best Practice Alerts", 'Hard stops' —demands an answer before can proceed.
- Interrupts clinician thought while thinking of DDx and Treatment plan.

- "Autocorrect" function won't stop putting in wrong word.
- ICD-10 diagnosis has "hard stop" demanding high specificity of dx- Out of administrative fear that may not be covered by insurance.
- Interrupts clinician train of thought.
- **Don't make a mistake!**
- **Constant mental overwork to compensate for poorly designed system-**
- **Chronic high stress at work.**