Advancing Care Conference Sneak Peek:
The Hidden Truth About Emotional Exhaustion and COVID from 250K Healthcare Voices
September 8, 2021
Upcoming Team Training Events

Webinars

• September 28, 2021 | 12:00 – 1:00 PM CT

• October 13, 2021 | 12:00 – 1:00 PM CT
  “Mindfully Addressing High Reliability’s “Robust PI” for Multi-Level, Multi-Organizational, Enterprise-Wide Improvement” Register here!

• October 20, 2021 | 12:00 – 1:00 PM CT
  Bonus webinar: “Reimagine Patient and Family Communication with Mobile Technology” Register here!

Courses
TeamSTEPPS for Change Leaders and Champions – Virtual - Register here!

Online Community Platform
Join Mighty Network to access exclusive content and connect with your peers to share stories, tools, and content.

Update: Advancing Care Conference Postponement
Given the ongoing impact of COVID-19 and as part of the AHA’s continuing efforts to support frontline health care professionals, educators, and leaders, we are postponing the inaugural Advancing Care Conference, originally scheduled for October 4-6 in Chicago, to 2022.
Today’s Presenters

Dr. Bryan Sexton, PhD
Director of the Duke Center for Healthcare Safety and Quality, and Associate Professor
Duke University Health System, Duke University; Department of Psychiatry

Joshua Proulx, BSEE
Chief Data Science Officer
Safe & Reliable Healthcare

Allan Frankel, MD
Chief Executive Officer
Safe & Reliable Healthcare
The Hidden Truth About Emotional Exhaustion and COVID from 250K Healthcare Voices

Bryan Sexton, Joshua Proulx, Allan Frankel

Sep 8, 2021
Agenda

- Burnout during Covid-19
- Evidence-based strategies to reduce burnout
- How we measure burnout
- SCORE survey
- Additional insights on COVID’s effect on burnout
- The underlying framework for highly reliable organizations
- Reflections on leadership and burnout
The Hidden Truth About Emotional Exhaustion and COVID from 250K Healthcare Voices

J. Bryan Sexton, PhD
Director, Duke Center for Healthcare Safety and Quality
Duke University Health System

twitter.com/dukehsq | www.hsq.dukehealth.org
Let’s get the elephants in the room out of the way… Impact of Covid-19, and Evidence that we can fix it...
We have data from 50,000 healthcare workers in Sept 2019 and Sept 2020
15% of respondents reporting concerning Emotional Exhaustion across 2019 and 2020 work settings.
% Emotionally Exhausted Before and During Covid-19 Overall & by Role

Overall (n=50412/50512)

Pre α=.93
During α=.94

t=-21.81, p<.001
% Emotionally Exhausted Before and During Covid-19 Overall & by Role

Pre α = .93
During α = .94

% Emotionally Exhausted

Overall (n=50412/50512)
Nurse (n=18927/18409)
Clinical Support (Medical Assistant/EMT/etc.) (n=1182/1047)
Nurses Aide/CNA/PCA/PCT (n=2437/2499)
Physician: Attending/Staff (n=1422/1457)
Social Worker/Counselor (n=558/593)
Pharmacist (n=808/888)
Technician (e.g. Surg./Lab/EKG/Rad.) (n=2086/1995)
Other (n=10912/12668)
Technologist (e.g. Surg./Lab/Rad.) (n=3786/3239)
Admin Support (Clerk/Secretary/Receptionist) (n=2354/2257)
Therapist (RT/PT/OT/Speech) (n=2714/2522)
Administrator/Manager (n=3226/2938)

t = -21.81, p < .001
COVID-19 impact is equivalent of 2.5 EMRs in 1 year

Burnout is intense, can we cause it to go down?
Randomized controlled trial of the “WISER” intervention to reduce healthcare worker burnout

Jochen Profit1,2, Kathryn C. Adair3,4, Xin Cui1,2, Briana Mitchell1, Debra Brandon5,6, Daniel S. Tawfik7, Joseph Rigdon8, Jeffrey B. Gould1,2, Henry C. Lee1,2, Wendy L. Timpson9, Martin J. McCaffrey10, Alexis S. Davis1, Mohan Pammi11, Melissa Matthews12, Ann R. Stark13, Lu-Ann Papile14, Eric Thomas15, Michael Cotten16, Amir Khan14, J. Bryan Sexton3,4

Received: 13 January 2021 / Revised: 26 April 2021 / Accepted: 6 May 2021
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Abstract

Objective Test web-based implementation for the science of enhancing resilience (WISER) intervention efficacy in reducing healthcare worker (HCW) burnout.

Design RCT using two cohorts of HCWs of four NICUs each, to improve HCW well-being (primary outcome: burnout). Cohort 1 received WISER while Cohort 2 acted as a waitlist control.

Results Cohorts were similar, mostly female (83%) and nurses (62%). In Cohorts 1 and 2 respectively, 182 and 299 initiated WISER, 100 and 176 completed 1-month follow-up, and 78 and 146 completed 6-month follow-up. Relative to control, WISER decreased burnout (−5.27 (95% CI: −10.44, −0.10), p = 0.046). Combined adjusted cohort results at 1-month showed that the percentage of HCWs reporting concerning outcomes was significantly decreased for burnout (−6.3% (95% CI: −11.6%, −1.0%); p = 0.008), and secondary outcomes depression (−5.2% (95% CI: −10.8, −0.4); p = 0.022) and work-life integration (−11.8% (95% CI: −17.9, −6.1); p < 0.001). Improvements endured at 6 months.

Conclusion WISER appears to durably improve HCW well-being.

Clinical Trials Number NCT02603133; https://clinicaltrials.gov/ct2/show/NCT02603133

Fig. 2 Effect of WISER on the percent concerning scale at 1 month post provided in brackets.
Overall, EHR metrics accounted for 1.3% of model variance \( (P = .001) \) compared with work culture accounting for 17.6% of variance \( (P < .001) \).
What if there were a metric so potent that it predicted clinical outcomes, operational outcomes, safety culture, and well-being?
Emotional Recovery -0.48
Emotional Thriving -0.40
Improvement Readiness -0.70
Work-Life Balance -0.54
Burnout Climate 0.83
Local Leadership -0.59
Teamwork Climate -0.64
Safety Climate -0.64


Adair, Kennedy & Sexton 2020
Personal Burnout

Burnout Climate -0.83
Local Leadership -0.59
Teamwork Climate -0.64
Safety Climate -0.64
Work-Life Balance -0.54
Improvement Readiness -0.70
Emotional Thriving -0.40
Emotional Recovery -0.48

Adair, Kennedy & Sexton 2020
Emotional Exhaustion and Burnout Climate’s Associations with Turnover and Preventable Medication Related SRS Reports

Table A: Spearman Correlations between HCW Well-being domains, Work Culture, and Operational Outcomes at the Work Setting Level

<table>
<thead>
<tr>
<th></th>
<th>Burnout Climate</th>
<th>Emotional Exhaustion</th>
<th>Work-life Balance</th>
<th>Work Culture Press Ganey</th>
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<tbody>
<tr>
<td>Turnover</td>
<td>.35**</td>
<td>.26*</td>
<td>-.14 (NS)</td>
<td>-.06 (NS)</td>
</tr>
<tr>
<td>N</td>
<td>N = 69</td>
<td>N = 69</td>
<td>N = 69</td>
<td>N = 65</td>
</tr>
<tr>
<td>Preventable Medication Related SRS</td>
<td>.35**</td>
<td>.41***</td>
<td>-.28*</td>
<td>-.15 (NS)</td>
</tr>
<tr>
<td>N</td>
<td>N = 68</td>
<td>N = 68</td>
<td>N = 68</td>
<td>N = 64</td>
</tr>
</tbody>
</table>

1 = low exhaustion, 3 = high exhaustion
The Leadership scale begins with the prompt “In this work setting, local leadership...”. Then individual items ask:

- Is available at predictable times.
- Regularly makes time to provide positive feedback to me about how I am doing.
- Provides frequent feedback about my performance.
- Provides useful feedback about my performance.
- Communicates their expectations to me about my performance.

Each 10-point increase in Leadership was associated with a 28% reduction in the odds of burnout for the respondent.
Providing Feedback: the secret sauce in Safety WalkRounds?
qualitysafety.bmj.com
“What are three things that are going well around here, and one thing that could be better?”
Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds

J Bryan Sexton PhD, Kathryn C. Adair PhD, Jochen Profit MD, Jonathan Bae MD, Kyle Rehder MD, Tracy Gosselin PhD, RN, Judy Milne RN, Michael Leonard MD, Allan Frankel MD

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https://doi.org/10.1016/j.jcjq.2021.04.001

Background

Interventions to decrease burnout and increase well-being in health care workers (HCW) and improve organizational safety culture are urgently needed. This study was conducted to determine the association between Positive Leadership WalkRounds (PosWR), an organizational practice in which leaders conduct rounds and ask staff about what is going well, and HCW well-being and organizational safety culture.

Methods

The study, titled "Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds," was completed at Duke University Health System, Durham, North Carolina, and involved senior leaders who were encouraged to conduct PosWR, an organizational practice in which leaders conduct rounds and ask staff about what is going well.
Do senior leaders ask for information about what is going well in this work setting (e.g., people who deserve special recognition for going above and beyond, celebration of successes, etc.)?

Do senior leaders ask for information about what is going well in this work setting (e.g., people who deserve special recognition for going above and beyond, celebration of successes, etc.)?

Mean of the work setting scores

- t = 6.32, p < .001
- t = 3.65, p < .001
- t = 5.50, p < .001
- t = 7.69, p < .001
- t = -4.32, p < .001
- t = -5.07, p < .001
- t = 6.39, p < .001

Perceptions of Institutional Support for “Second Victims” Are Associated with Safety Culture and Workforce Well-Being

J. Bryan Sexton PhD (is Associate Professor, Department of Psychiatry, Duke University School of Medicine, and Director, Duke Center for Healthcare Safety and Quality, Duke University Health System, Durham, North Carolina,) Kathryn C. Adair PhD (is Assistant Director, Duke Center for Healthcare Safety and Quality.,) Jochen Profit MD (is Associate Professor, Perinatal Epidemiology and Health Outcomes Research Unit, Division of Neonatology, Department of Pediatrics, Stanford University School of Medicine, and Lucile Packard Children's Hospital, Palo Alto, California,), Judy Milne RN (is Patient Safety Officer, Duke University Health System,), Marie McCulloh RN (is Patient Safety Officer, Duke University Health System,), Sue Scott PhD, RN (is Nurse Scientist, University of Missouri Health Care, Columbia, Missouri,), Allan Frankel MD (is Chief Executive Officer, Safe & Reliable Health Care, Evergreen, Colorado)
Perceptions of Institutional Support for Are Associated with Safety Culture and Well-Being

J. Bryan Sexten, PhD, et al.

Objective: This study was performed to determine whether health care worker (HCW) support for second victims was associated with institutional safety culture and well-being.

Methods: HCW's perceptions of support were measured using the Safety Culture Questionnaire (SCQ), and institutional safety culture was measured using the Survey of Occupational Safety Culture (SCORE).

Results: Of the 110 respondents, 61.5% of respondents reported that institutional support was adequate, compared to 38.5% who reported low support. The mean score for institutional support was 4.1 (SD = 1.2), compared to 3.0 (SD = 1.4) for institutional safety culture. A significant positive correlation was found between institutional support and institutional safety culture (r = 0.71, p < 0.01).

Conclusion: Perceived institutional support for second victims was associated with institutional safety culture and well-being. Improvements in support can improve the overall well-being of HCWs.

Patient safety measures can be difficult to implement, but preliminary evidence suggests that increased support for second victims may lead to improved patient outcomes.

Figure 1: The graph shows the quartile distribution of support for second victims, as measured by agreement with the statement "Individuals emotionally traumatized by an unanticipated clinical event within my work setting receive appropriate support from those involved.

Figure 2: Shown here are SCORE domains by quartile, as determined by agreement with the statement "All respondents are included in the peer support network.

Figure 3: The figure shows the relationship between institutional support and institutional safety culture.
SCORE Safety Culture and Well-being Survey

• Psychometrically superior to any other published instrument
• Incorporates workforce well-being into assessments of norms
• Predicts clinical and operational outcomes
• Published Links to:
  – Leader Walkrounds
  – Positive Walkrounds
  – Second Victim Support
  – Preventable Harm
  – Turnover
  – Disruptive Behaviors

Personal and Professional Factors Associated With Work-Life Integration Among US Physicians

Daniel S. Tawfield, MD, MS; Tel D. Sharon, MD; Louise H. Datwyler, MD, MAFF; Christine A. Sinsky, MD; Colin P. West, MD, PhD; Aleria S. Davis, MD, MD; Peter G. S., MD; Kathryn C. Atul, PhD; Whitney T. Tucker, MD, PhD; Joshua Proffit, MD; MPH; J. Bryan Savaos, MD

Abstract

**IMPORTANCE.** Poor work-life integration (WLI) occurs when career and personal responsibilities come in conflict and may contribute to the ongoing high rates of physician burnout. The characteristics associated with WLI are poorly understood.

**OBJECTIVE.** To identify personal and professional factors associated with WLI in physicians and identify factors that modify the association between gender and WLI.

**DESIGN, SETTING, AND PARTICIPANTS.** The cross-sectional study was based on electronic and paper surveys administered October 2017 to March 2018 at private, academic, military, and veterans’ practices across the US. It used a population-based sample of US physicians across all medical specialties. Data analysis was performed from November 2019 to July 2020.

**MAIN OUTCOMES AND MEASURES.** WLI was assessed using an 8-item scale (0-100 point scale, with higher scores indicating favorable WLI), alongside personal and professional factors. Multivariable linear regressions evaluated independent associations with WLI as well as factors that modify the association between gender and WLI.

**RESULTS.** Of 59,897 physicians completing surveys, 4370 provided complete responses. Of the physicians who provided complete responses, 2799 were men, 3419 were women (44.1%), and 3650 were married (82.4%), and the mean (SD) age was 52.3 (10.0) years. The mean (SD) WLI score was 55.23 (women reported lower [worse] mean [SD] WLI scores than men overall 51.22 [1] vs 57.22, median difference, -1 [IQR: 0.25]) (P < .001). In multivariable linear regression, lower WLI was independently associated with being a woman (linear regression coefficient, -6.5, 95% CI, -9.2 to -3.9, P < .001), as well as being aged 35 years or older (odds: 35 to 44 years: linear regression coefficient, -7.5, 95% CI, -9.7 to -5.3, P < .001; single: linear regression coefficient, -1.3, 95% CI, -2.1 to -0.5, P < .001; married: linear regression coefficient, 0.2, 95% CI, 0.0 to 0.5, P = .01); and call nights (linear regression coefficient, -1.1, 95% CI, -1.6 to -0.5, P < .001), and being in emergency medicine (linear regression coefficient, -18.8, 95% CI, -24.0 to -13.7, P < .001), urology (linear regression coefficient, -11.4, 95% CI, -15.0 to -7.8, P < .001), general surgery (linear regression coefficient, -6.6, 95% CI, -9.8 to -3.3, P < .001), and family medicine (linear regression coefficient, -3.1, 95% CI, -4.4) (reference category: internal medicine subspecialties). In interaction modeling, physician age, youngest child’s age, and hours worked per week modified the associations between gender and WLI, such that the largest gender disparities were observed in physicians who were aged 45 to 54 years (estimated WLI score for women, 49.9% CI, 47.5-51.3; estimated WLI score for men, 57.9%, CI, 55.9-59.8; P < .001); had youngest child aged 23 years or older (estimated WLI score for women, 51.9%, CI, 48.5-55.4; estimated WLI score for men, 56.9%, CI, 53.8-59.6; P = .025); and were working less than 40 hours per week (estimated WLI score for women, 51.9%, CI, 45.6-58.6; estimated WLI score for men, 59.9%, CI, 56.6-63.2; P < .001).

**Key Points**

**Question** Which personal and professional factors are independently associated with work-life integration in physicians, and which factors modify the association between gender and work-life integration?

**Findings** In this cross-sectional study based on survey data of 4370 US physicians, women physicians consistently reported significantly worse work-life integration scores independent of other personal and professional factors, with a gender disparity most pronounced for midcareer physicians, those with adult children, and those working fewer hours per week.

**Meaning** These findings suggest that systemic change is needed to help physicians achieve appropriate integration of work life and home responsibilities.

**Supplemental content**

Author affiliations and more information are listed at the end of this article.
Table 2. Multivariable Linear Regression Showing Personal and Professional Factors as Independent Variables Associated With Work-Life Integration (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient (SE)</th>
<th>P value</th>
<th>Overall P value^b</th>
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</thead>
<tbody>
<tr>
<td>Hours worked per week (vs &lt;40 h)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>-2 (1.0)</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>-9 (1.0)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>-16 (1.1)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>70-79</td>
<td>-22 (1.4)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>≥80</td>
<td>-27 (1.5)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Call nights per week (per night)</td>
<td>-1 (0.2)</td>
<td>&lt;.001</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: NA, not applicable.

^a N = 4370 respondents. Dependent variable is work-life integration score (0-100 point scale). Estimates via multivariable linear regression with all covariates shown.

^b Overall P values for categorical variables via Wald test.

Figure 2. Multivariable Interaction Models Estimating Work-Life Integration (WLI) Scores

Estimated WLI scores showing the interactions between gender and (A) mean hours worked per week, (B) physician age in years, and (C) age of youngest child in years. Models also adjusted for relationship status and specialty. Error bars denote
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Integrated Survey with Latest Science
Engagement, Burnout/Wellness, Resilience, Improvement Readiness, Psychological Safety

Add Your Questions
Maps to AHRQ SOPS + SAQ
Able to add custom questions and compare YoY data

Diagnostics that Support Action
Data visualizations + automated reports; themes and trends across organization
Automated survey debriefing and action planning to develop and track improvement plans

Enhanced Benchmarking
Includes >700 organizations; largest burnout benchmark

S  Safety
C  Communication
O  Operational Risk
R  Resilience/Burnout
E  Engagement
Three Tiers of Real-time Analytics on SCORE Platform
Insights Tailored for Managers to Take Action, Customizable

Notable Insights by Percentile and Key SCORE Items
371 respondents in 20 work settings at Demo Hospital

Key Drivers of Culture & Engagement (Driven is good)

<table>
<thead>
<tr>
<th>Key Driver</th>
<th>Percent</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>67%</td>
<td>72%</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>Local Leadership</td>
<td>74%</td>
<td>78%</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td>Burnout</td>
<td>32%</td>
<td>58%</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>Turnover</td>
<td>45%</td>
<td>49%</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>Work/Life Balance</td>
<td>44%</td>
<td>46%</td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>Growth Opportunities</td>
<td>71%</td>
<td>73%</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Intention to Leave</td>
<td>57%</td>
<td>49%</td>
<td>20%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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Scatterplots of Key SCORE Domains
371 respondents in 20 work settings at Demo Hospital
Culture exists locally within each unit/department
You can improve the facility culture by targeting struggling teams
Personal Burnout by Department Variation within the Benchmark
You can improve the facility culture by targeting struggling teams
### Personal Burnout Changes by Race/Ethnicity

Data: Pre-Survey of 34,119 respondents in 90+ hospitals: Q1 2020  
Post-Survey: Q2 2021

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Pre-Survey 2020</th>
<th>Post-Survey 2021</th>
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</thead>
<tbody>
<tr>
<td>Black or African American (3726)</td>
<td>66</td>
<td>57</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (88)</td>
<td>63</td>
<td>54</td>
</tr>
<tr>
<td>Hispanic or Latino (2128)</td>
<td>62</td>
<td>53</td>
</tr>
<tr>
<td>White (26009)</td>
<td>61</td>
<td>52</td>
</tr>
<tr>
<td>American Indian or Alaska Native (113)</td>
<td>60</td>
<td>53</td>
</tr>
<tr>
<td>Two or More Races (377)</td>
<td>60</td>
<td>46</td>
</tr>
<tr>
<td>Asian (1678)</td>
<td>58</td>
<td>50</td>
</tr>
</tbody>
</table>

Higher is better
Personal Burnout Changes by Race/Ethnicity

Data: Pre-Survey of 34,119 respondents in 90+ hospitals: Q1 2020
Post-Survey: Q2 2021

Higher is better

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2020 Personal Burnout Percentile</th>
<th>2021 Personal Burnout Percentile</th>
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</thead>
<tbody>
<tr>
<td>Black or African American (3726)</td>
<td>75</td>
<td>40</td>
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<tr>
<td>Native Hawaiian or Other Pacific Islander (2128)</td>
<td>63</td>
<td>28</td>
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<tr>
<td>Hispanic or Latino (26009)</td>
<td>60</td>
<td>24</td>
</tr>
<tr>
<td>White (113)</td>
<td>53</td>
<td>21</td>
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<tr>
<td>American Indian or Alaska Native (377)</td>
<td>49</td>
<td>7</td>
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<tr>
<td>Two or More Races (1678)</td>
<td>49</td>
<td>16</td>
</tr>
<tr>
<td>Asian</td>
<td>40</td>
<td>16</td>
</tr>
</tbody>
</table>
Personal Burnout Changes by Gender

Data: Pre-Survey of 35,128 respondents in 90+ hospitals: Q1 2020  ▶  Post-Survey: Q2 2021

Higher is better
Personal Burnout Changes by Gender & Race/Ethnicity

Data: Pre-Survey of 34,103 respondents in 90+ hospitals: Q1 2020    Post-Survey: Q2 2021

Higher is better
Personal Burnout Changes by Age


Higher is better

![Bar Chart showing Personal Burnout by Age]

Numbers represent percentiles:
- 20 and under (90)
- 21 - 30 (4160)
- 31 - 40 (7911)
- 41 - 50 (8207)
- 51 - 60 (9465)
- 61 - 64 (3302)
- 65 and older (2016)
Effect of Work from Home during COVID

<table>
<thead>
<tr>
<th>CULTURE</th>
<th>WFH &lt;50 hours/week</th>
<th>WFH 50+ hours/week</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Percent Positive</td>
<td>Percent Positive</td>
</tr>
<tr>
<td>Improvement Readiness</td>
<td>67%</td>
<td>75%</td>
</tr>
<tr>
<td>Local Leadership</td>
<td>64%</td>
<td>73%</td>
</tr>
<tr>
<td>Burnout Climate‡</td>
<td>36%</td>
<td>54%</td>
</tr>
<tr>
<td>Personal Burnout‡</td>
<td>52%</td>
<td>67%</td>
</tr>
<tr>
<td>Emotional Thriving</td>
<td>59%</td>
<td>62%</td>
</tr>
<tr>
<td>Emotional Recovery</td>
<td>67%</td>
<td>76%</td>
</tr>
<tr>
<td>Teamwork</td>
<td>46%</td>
<td>56%</td>
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<tr>
<td>Safety Climate</td>
<td>58%</td>
<td>68%</td>
</tr>
<tr>
<td>Work / Life Balance</td>
<td>62%</td>
<td>74%</td>
</tr>
</tbody>
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Data: Pre-Survey of 90+ hospitals: Q1 2020  Post-Survey: Q2 2021

<table>
<thead>
<tr>
<th>ENGAGEMENT</th>
<th>WFH &lt;50 hours/week</th>
<th>WFH 50+ hours/week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent Positive</td>
<td>Percent Positive</td>
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<tr>
<td>Growth Opportunities</td>
<td>63%</td>
<td>66%</td>
</tr>
<tr>
<td>Job Certainty</td>
<td>70%</td>
<td>73%</td>
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<tr>
<td>Intentions to Leave</td>
<td>86%</td>
<td>90%</td>
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<tr>
<td>Decision Making</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>Advancement</td>
<td>19%</td>
<td>26%</td>
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<td>Workload Strain</td>
<td>66%</td>
<td>77%</td>
</tr>
</tbody>
</table>
Challenges & Opportunities Posed by Covid 19
Did Covid Unify or Diversify Us?

- Highly individualized experiences
- High Reliability: *Reluctance to simplify interpretations*
- Leaders need a **sophisticated lens** moving forward
Burnout is the Buzzword, But…

- We must be ‘reluctant to simplify interpretations’
- We must not assume we understand cause, symptom or solution

- Some people are less burned out
- Some people are more burned out
- Burnout shows up in different ways
- Burnout occurs at different times
Understanding Burnout

Symptoms of Burnout

- Frustration
- Emotional exhaustion
- Cynicism
- Inefficacy
- Depersonalization

The ‘what’ but not the ‘why’
Categorizing the Causes of
Frustration, Emotional Exhaustion, Cynicism, Inefficacy, &
Depersonalization

Leadership Causes

System Causes

Cultural Causes

Knowledge Causes
LEADERSHIP
Non-Negotiable Respect
Guardians of Learning
Exemplars of Culture
Visible Action

CULTURE
Courage
Agency
Community
Collaboration

Knowledge of Learning
Exemplars of Culture
Visible Action

Leadership Skills
Leadership Activities
Leadership Behaviors

Learning System
Improve
Learn

Data
Transparency
Consensus & Alignment
Healthy Environment
Teamwork & Collaboration
Personal Accountability

Self-Reflecting
Improvement-Capable
Sustainable
LEARNING
Thinking of a time when you have personally experienced burnout in the last twelve months...

- Which of these symptoms resonate the most with your experience?
  - Frustration, Emotional Exhaustion, Cynicism, Inefficacy, Depersonalization
- Can you identify the causes?

**Leadership Causes**

**Knowledge Causes**

**Cultural Causes**

**System Causes**
Factors Influencing Burnout and Resilience

Do I feel valued by the organization?
Do I have a voice?
Do I feel supported in the work I do?
Do I have the tools and resources to do my job?

Personal Accountability
How effectively do I provide these things to others?
Transformational Leaders

- Create meaningful relationships of trust, psychological safety and community
- Set a positive tone and proactive stance
- Ask questions (Appreciative Inquiry) and listen
- ‘Think out loud’: establish shared mental models “Here’s what I’m thinking, what are you thinking?”
- Encourage and welcome diverse opinions, ideas & solutions
- Feel safe to “improvise” and learn

How do I ‘show up’?
When do I ‘show up’?
6 Simple Rules

1. Be Visible; ‘Go to the Gemba’

2. Listen... Listen... Listen

3. Pause and Reflect

4. Be Curious and Appreciative

5. Message the Mission. Mobilize others for a collective purpose

6. Ask for their Thoughts and Ideas
Effective visual management systems drive cultural change, learning, staff engagement in “voice” and problem solving and allows the real-time sharing of data, stories and progress.
Visual management is not a panacea...

- More than just another ‘tick-box initiative’

- Visual Management Systems are a high-reliability intervention that diminishes leadership, cultural, knowledge and system causes of burnout, and builds team resilience.

Stories & Exemplars ‘from the field’
Burnout Reflections

Some leadership pitfalls in an environment of burnout:

- Heroism
- The pizza party
- The right actions but the wrong communication

Some leadership successes in an environment of burnout:

- Visual management is daily work
- Measuring culture
  
  SCORE

- Showing up, no matter what
- Effective bidirectional communication ensuring value alignment
Smoothing the Path Ahead

Leaders need:
1. To know what burnout is (symptoms)
2. To understand where burnout exists (data)
3. To explore the causes of burnout (causal analytics)
4. To co-create wellness with the frontline (solutions)
Questions?
Stay in Touch!

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