Beyond Burnout: Returning to Satisfaction and Purpose in Health Care

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- [Calista] Our course today is titled, Beyond Burnout: Returning to Satisfaction and Purpose in Health Care and it is my pleasure to welcome to physicaltherapy.com, Dr. John Corsino. Dr. Corsino is a hospital physical therapist and writer who is interested in quality improvement, purposeful vocation as a right and sustainable improvements for all who participate in the healthcare system. So, John we are so pleased to have you here with us today and talking about this very popular topic and at this time I'm gonna turn the microphone over to you.

- [John] Thanks so much Calista. Good morning everyone or good early afternoon. Thanks for joining me. So, as Calista mentioned I'm a hospital PT really interested in making sure everyone has the opportunity that they deserve to see the value of the good work that they do and I'm gonna outline some ways that I think we can do that in our healthcare system and how that'll help us and help our patients. So just to take a quick look at the learning outcomes, my goals in the next two hours are to talk about potential sources of dissatisfaction within our system, and to identify strategies for providers to move past those boundaries and identify ways to realize the joy in our work, as well as strategies for leaders to cultivate joy for the workers in our system. And so my framework is this, vocational satisfaction is a really complicated but important thing and most literature as well as main stream media recently frame burnout as a problem of providers. Something that needs to be solved through self care, and thereby identify solutions as provider choices and I feel differently. I don't think that's completely wrong but I think that the proximate cause of dissatisfaction in our system is actually organizational culture and the culture of the larger healthcare system of which we're all part. And this is in my view under discussed in a literature as the causal or contributing factor to provider dissatisfaction and so that's the main focus of my views and we're gonna discuss that at length. So about me. A little more about myself. I'm gonna tell the story about how I became interested in this topic, what I've done personally and at my hospital and with my patients to be as satisfied as I think I can with my work. So, I'm a hospital physical therapist, I have been for a little over five years since I graduated from PT school. Started out briefly in acute rehab, and found the hospital setting very appealing for a number of reasons. I practice now primarily in Intensive Care, but also cover the Emergency Center, Med-Surg settings and I also evaluate and treat patients with vestibular problems in the hospital setting. Recently I became the Process Improvement Coordinator in this role and so I get to work at the inner section between the Rehab Department in my hospital and larger patient care policies and that's been very exciting and been a great opportunity to help improve what we're doing for patients which certainly makes it easier to be satisfied in the work that I'm doing as a clinician. I also write about the healthcare system about what our think are its deficiencies and particularly about how we can solve them. A sort of summary of my views in that area is that I think PT especially in the hospital setting is an incredibly satisfying job right now but that there are also many really large and serious barriers to clinicians being able to cultivate the enjoyment in their work that they deserve and at the same time that are barriers to satisfaction also are barriers to the best outcomes that our patients could realize. So where I practice I think is an important piece of my story. It's an independent community hospital, small, just fewer

than 300 adult beds but growing and by growing I mean two things. Not just that we're increasing the number of beds that we have but growing in terms of the programs that we offer and the quality of services that we have definitely. And most important for me is that this hospital is my home hospital. This is in the town where I grew up, and I didn't think I'd be back so quickly after graduating from PT school but the frustrations that are pervasive in our healthcare system definitely mean more to me to try to improve in this setting because it is where I grew up and because I have connections to so many people who are treated here, I'm more personally invested in quality improvement and care more about making sure that we move past these barriers in this hospital. But before I go any further I'd like to know just a little bit about you. If you are watching this at a computer with a keyboard in front of you, if you could enter a really brief comment about even the kind of setting that you work in. I assume that many therapists watching this presentation work in acute care but if you could type in a quick message I'd love to see just where you work, so I know more specifically about what to talk about next. So I'll give it a minute for those answers to come in and I'll talk a little bit about what we find. All right, great. Thanks everyone for answering.

So, plenty of acute care, certainly some home care, SNF, utilization management. Lots of interesting answers there. So good. So, we'll talk about a broad range of barriers of what they mean in different settings and how we can move past them in different settings as well. Thanks for answering. So, a bit of background about how I came to be presenting this topic. So, in 2017, Sharon Gorman wrote this great president's message in the "Journal of Acute Care PT" about burnout and The Fourth Aim which is the Institute of Healthcare Improvements, sort of buzzword for their idea that provider satisfaction is an important part of an effective healthcare system, and she made some great points which I don't disagree with at all about focusing on self care, enjoying work, life balance, taking time for vacation and most importantly in my view emphasized the value of control over work environment and I don't disagree at all with anything she said but my perspective about burnout and satisfaction, I view it from the opposite direction. I think that burnout focuses on the presence of something negative but I think what we're actually looking at is a deficiency of something really important which is that provider satisfaction. It's not semantic. It will dictate sorta how we solve these problems down the line. So I wrote a response to Dr. Gorman. Before I go further I'll just outline quickly the Quadruple Aim for any who are not familiar. So IHI, Institute for Healthcare Improvement came out awhile ago with their Triple Aim which is this idea that better care and better health will reduce cost and that we can get into this positive feedback where becoming becoming better in one area helps us to get better in every other area. And then they recently added this fourth aim, the idea that removing these barriers to good care should also help people be more satisfied, and cultivate more joy from their work which is something that I definitely agree with wholeheartedly. The IHI presents this in a more rigid framework from the background of improvement science and I was really excited when I saw this paper noted in this slide here. It's a very scientific approach to what's otherwise viewed as kind of a soft and fungible concept of joy in work. It really take a sensible, logical approach to something that otherwise can be difficultly to discuss logically. I have no affiliation with

the IHI. I'm discussing this with their permission. So this is the reply that I wrote to Dr. Gorman. So, I brought up the idea that I think work, life balance is important but that I don't view that as the be all end all of cultivating provider satisfaction. I view it instead as advancing our clinical practice and practicing at a high level in a way that we can maximize our ability to help patients instead is the most important way to find satisfaction in our work and I discussed the idea of high impact time and I frankly admitted that in 40 hours that I spend at work I think I'm spending maybe 25% of that time on things that I view as really high impact for patients. A lot more time on clerical work and organizational type problems, and I brought up the idea that the relationship between volume and potential for impact is the real source of dissatisfaction and I'll describe that more at length but an overview, if we're doing a large volume of work, I don't think that inherently needs to be dissatisfying at all. If we're doing a large volume of really important work that helps people achieve and maintain health, I think we're gonna be satisfied. We might be tired, we might be challenged, but I don't think we're gonna be dissatisfied whereas on the other hand if we're doing a large volume of relatively low impact work, I think we're gonna be dissatisfied no matter what, even if we're doing a small volume of low impact work. I think if we're doing things that we do not view as important because they don't help our patients as much as we feel like we could, they're gonna be dissatisfied and so I asked the question of where the breakdown is in our system leading to this problem?

So, burnout is something that we see and will see and hear increasingly in literature and in mainstream media. These are just some articles that have been sort of widely disseminated about this idea. I think having this idea out there as a buzzword creates a lot of harm and I think it frames and shapes our thinking about the issue to a certain extent and so the more that we can do to change our language now about this topic the more we can change the narrative going forward and help dictate the solutions. So, satisfaction and burnout are things that have actually been examined in research for years particularly among physicians and nurses but the pace of that discussion if not research is certainly accelerating, again mostly owing now to I think mainstream media discussions. So the more that we as providers actually experiencing this phenomenon can get ahead of that in our own discussion, I think the better we can dictate the next steps of what happens in solving these problems. So burnout, it's not that burnout's not a real problem, but I think that it approaches as I mentioned healthcare, the healthcare system's limitations from the wrong perspective. It's sort of a top down look at this is a thing that exists that's wrong, whereas inversely I think what we're seeing is insufficient satisfaction and that I believe is something much larger and more complicated than the existence of burnout. It's a deficit of satisfaction. There are many different sources and many different solutions. As a PT I may be biased but I think that physical therapists are an incredible bargain in healthcare right now and I think that all our healthcare providers do but particularly PT's I think is something that clinicians should be extremely proud of. I think our perspective about illness, disease and participation is unique. I think it's a really deficient part of how the healthcare model works right now, especially the sorta fee for service biomechanical model. I think our perspective from our training is uniquely valuable and important right now. I think we

should be really, really proud of what we do every day. And so I think as an extension to that that our, if we focus on self care and even if we can create really good balance and be very satisfied when we're not at work, I think that focusing on self care alone is just delaying the problem. I think it's just kicking the can down the road. We need to confront what the real problem is as soon as we can and start to work on solutions and maybe in the mean time as we start to solve the systemic problems, we can focus on self care as well. I think seeing this problem clearly for what it is is the first step of addressing its causes and moving past its limitations. And so, self care is good. I think it's an important part of healthy lifestyle definitely. I know we tell our patients that. We need to believe and practice it ourselves, but I think it's different than the right way to cultivate deeply meaningful relationship, excuse me, relationships with our work to which we're all entitled. So, I'm gonna read a quick quote here from Bill O'Brien who is the one time CEO of Hanover Insurance. I don't know much about his organization but I know that he and this company are discussed extensively in management literature as a company that became a learning organization and did a lot of positive culture change that enabled them to be effective and last and the idea is that... I'll read the quote first.

So, "There are teachers, social workers, "and clergy who work incredibly hard "until they're 80 years old and never suffer burnout "because they have an accurate view of human nature "of our potentials and limitations." And I hope everyone knows people like this who are really dedicated and work tirelessly for the good of others and are able to do that for long happy careers because they see the importance of what they're doing and they can connect their efforts with the results that it helps people achieve and I think that people doing jobs that they love even if they're very challenging and tiresome ones, I don't think will become burnout if that's where we are. I think these are problems ubiquitous in healthcare and in education. I think education experiences a lot of the same problems in self care right now which mainly is a focus in metrics rather than processing culture. I think these are professions where everyone should be able to see the possibility for long happy careers doing important work and right now the systems focus on other things is limiting is from doing that. So, inherently I think in healthcare what could be more satisfying than helping people, especially those who need it most when they're at their most vulnerable points? I think the industry itself lends an effort towards developing valuable skills, furthering clinical capacity. We're working closely, especially as PT's I think we're working more closely on a better interpersonal basis than anyone else with those who really need our help and overcoming challenges daily. And even if this work tests us unrelentingly and exhausts us and finds all of our limits, it demands the best of what we have to offer too and that's something that you can't emulate. Either you have that in your culture or you don't. So, a little bit of background about vocational satisfaction. I looked at a lot of different data and literature about this and so I'm gonna discuss how we measure it and what the results are in the U.S. and then also compare it with some other systems. In general vocational satisfaction is higher in the U.S. than it is in many countries, but we use different metrics. If you look at Gallup or Pew research or Bureau of Labor Statistics, you'll find things, a lotta data points, but you'll find things like, I'm satisfied with my compensation. I'm satisfied with the amount of time off that I have, and we

take a much weaker emphasis on I'm satisfied with how meaningful my work is and the opportunities that it affords me to do what I set out to do. In some circumstances satisfaction is higher among tradespeople than professionals which I found very interesting and I'm certainly going to discuss. But think about that for a moment. Do you yourself or do you know anyone who is maybe less educated if not better experienced trades person who's very satisfied with what they do? And then most interestingly and I think this speaks very loudly to the message that work life balance is not the solution is that work satisfaction is higher among full time workers than it is among part time workers. And so that means to me that stepping back and reducing involvement in what you're doing is not satisfying. It's less satisfying than advancing practice and doing things at a really high level. So vocational satisfaction in the U.S. improves with income up to the point where workers are making about $75,000 a year. This does vary by area associated with costs of living in those areas, and perhaps unsurprisingly it's better in non-profits than it is for private companies and I think this is probably due to the fact that people work or choose selectively to work for non-profits are mission driven and set out to do something in particular besides get the best compensation that they can. But there's definitely a mismatch where, or there's definitely a potential for mismatch where if we're compensated beyond what we think our work is worth, that produces a different type of dissidents.

So, if we're someone doing a primarily administrative or clerical job being compensated very well for that, certainly we enjoy the fact that we're well compensated for our time but it produces a feeling that this is not the right degree for us. You have to be compensated in line proportional to the value of the work that you're doing. I think this is true everywhere. I think it's especially true in healthcare. So, most literature about satisfaction examines physicians and registered nurses. More than half of both these groups are categorized as burnt out, and there are some data about many professions, but I'm surprised especially with recent changes that we're not talking about these things as they relate to rehab. So, we have I think some really unique factors working both for and against us. And if you're doing a survey asking people about their satisfaction there's gonna be an element of people who would set out to complete that survey already have certain feelings, mainly that they are dissatisfied if they're gonna go out of their way to complete a survey about satisfaction. But most interestingly, so among physicians between 2011 and 2014 dissatisfaction increased a lot among surveys that were already being done and there's been no enormous change in healthcare during those four years. One thing, if there's been anything that changed quickly has been I think advancing focus on metrics and increasing emphasis on the electronic health record. You hear physicians say things and write things like they feel like they're managing care from a desktop and certainly there are data that, the huge majority of physician time is spent at a computer which is certainly not the goal that many of us, many healthcare providers across all disciplines set out with. We wanna do interpersonal work to be hands on with people. But as a note, physicians as a group are less satisfied with work life balance as well. And this is interesting because physicians in consideration of their extensive training are better compensated than average people who are employed in the U.S. and so for them to be

less satisfied with work, life balance I think also speaks volumes about where the problems might be in our system and helps to guide what we can do about those. So, RNs compared to general population are, they have twice the incidents of depression as the general population. It's 18% of RNs per available literature qualify as depressed per standardized measures versus 9% of the general population and by settings those working in skilled nursing facilities are more depressed than those working in hospitals, and more burnout than those working in other settings and these don't by themselves these data don't say anything but you can certainly use them in the context of everything else you can observe about the system and sorta understand where the problems are and why they might exist. Most interestingly at the Henry Ford health system in Detroit, workers engage with health inequity projects, focus on reducing inequity between populations reported being seven times more engaged with their work and if you think about Detroit there is a high level of income and inequality there and a number of types of inequity, and to be someone in that setting, and working on equalizing that disparity, you can get a sense for how people would be more engaged to in that type of work.

So one of my favorite topics as it relates to satisfaction is the idea of ownership. So the idea that tradespeople are more satisfying than licensed professionals actually comes from a Canadian labor study where's trades are a little bit more different than they are here. But I think there's an important point there. So, if you're a craftsperson and you're making something and you're controlling the outcome of that product from start to finish and you see your own effort and your own skill in everything that you've learned in that final product, you're gonna care more about the outcome than someone who's putting something together around an assembly line or just a node as part of a system who does not own the finished product. And healthcare I think at one time was probably very interpersonal and afforded a great degree of control over final outcomes for clinicians but now is increasingly fragmented and we're all working on different parts and the more specialized we become I think the more focused we are on our narrow piece of what we can do for patients and the results are far from direct. So if you are a clinician and you show up to work say in your outpatient clinic one day and you've really researched everything you can do for this one patient and you do everything you can, the results are still very far from direct. You don't see immediately the results of the work and effort and time and compassion that you've put into taking care of that one patient. And then in healthcare we encounter a lot of wrong goals where the things that are best for patients are different than the goals in the health system, and incentives and ideas kinda clash and goals are not aligned. So, individual control to return to that, Dr. Gorman again mentioned that point about control over work environments which I think is very important. But individual control is something that's highly correlated with satisfaction in work. If you're a bright and motivated person in a job that provides an opportunity to do good and meaningful work, then control or autonomy in that job is just sort of a way to facilitate your capacity to do the things that you wanna do. And there's another part to that idea where if two people are doing the same work in the same circumstances, they might find totally different degrees of satisfaction based directly upon the control they exercise on operational

type decisions and how involved they are with organizational strategy in that regard. And so the fundamental reasons for that I'm sure can be analyzed at length, but I think it makes sense just superficially too if you're involved in planning and able to do things that make sense to you as again a bright motivated person, then you're gonna be more satisfied in what you're doing. And then also in the literature interestingly enough, not in healthcare but just in a broader sense, our scenarios where having too many choices can paradoxically lead to dissatisfaction. I think this is a different phenomenon than too much control I think, but having insufficient direction or too many choices can lead to dissatisfaction but to me individual control over work is doing the work that I want to do when I want to do it in the way that I want and under the circumstances of my choosing and I think that this is an expression of a bigger, broader, excuse me, organizational culture. So value alignment. If my values are the, if the values of my organization are the same as my personal values, I'm gonna be more satisfied than if I'm goin' to work doin' something different then what I believe in. If the work that's important to me is the work that's important to my employer then I'm going to be more satisfied working for that employer. The idea I think everyone's very, very optimistic and positive in healthcare for the most part and I think many of us start off at least with the idea that smart and dedicated clinicians couldn't be exploited at least not without knowing it. And so I'm gonna talk about some barriers and again mismatch incentives that lead to the limitation of our ability to do the things that make the most sense to us.

So as an example and I'm sure this is different for every setting but in the hospital setting as a physical therapist, to me this means seeing the right patients at the right time, thereby maximizing my own utility to help the people who can benefit from what I know and the skills I developed and the time I have. To be able to practice at a high level because the easier tasks who can be done by anybody are already met is something that will lead to satisfaction and so for example at our hospital one thing that I've been lucky to be involved with is this project of improving patient mobility, and so we have, our goal has been to shift therapy interactions from just mobilizing patients, patients especially that can be mobilized by aids or nursing staff so that we can spend more time with people who really need a lot of PT intervention. I think that the closer we get to high level practice, the more satisfied we're going to be and it might mean totally different things in different settings. In the hospital I think there are a lot of different views about that. Certainly contributing to differential diagnosis is a big piece. Mobilizing patents in Intensive Care is something I think is a probable PT skill. I'm sure in outpatient there are a lot of really specialized things about which I'm not even aware and in home care and in SNF settings as well but the closer we can get to doing the most challenging and skill intensive thing that we know the more I think that we're gonna be satisfied. So, to back up the theory a little bit, I don't think we can get too far in any discussion about work fulfillment, purpose, satisfaction, without touching upon Maslow's hierarchy of needs. And so in talking about income, we've touched upon physiological and safety needs at least by proxy but on the higher level needs I think sense of connection isn't something that happens of course exclusively through work and hopefully not even primarily through work but in a profession like healthcare, I think that connections with students and patients and peers and everybody with

whom we work is an important part of doing this job well and being satisfied in it. I think esteem is really important in any career, not just through the domain of status but also self esteem of how proud we feel of what we're doing which is of course based on how important and how impactful we perceive our work to be and self actualization, becoming the best that we can is part of any pursuit. Not in the least work and so an extension of that domain involves helping others achieve self actualization and so if it means advocating for change within our system then that's something that we need to see and to be able to focus on. So, Maslow wrote that we're unique individuals with different skills and needs but also have this set of common needs and that to be satisfied our work needs to connect us to our unique potential. He summarized it with, "What a man can be, he must be," and what this means to me is you're never gonna have the level of satisfaction that you could if you're doing something at a lower level then the most challenging thing you could be doing. There's a reason these ideas come up so often. I think we've all as healthcare professionals, we've all encountered them probably as undergrads, again in grad school maybe but if we're doing jobs, even just part of our time, if we're doing work that could be done by anybody then we're not gonna perceive the greatest satisfaction and fulfillment that we could. And I think the opposite perspective of this is when we're drawn to a high degree of specialization, it's certainly exciting to develop further clinical skills, especially when we perceive the need for those skills, an area that we worked but this is just sort of an advancement along this ladder I think. We're working to challenge ourselves to connect our unique capacities with what needs to be done to help people as much as we can.

So a little more purposeful vocation. I think in the U.S. we all agree about housing as a right. It seems like we're unfortunately not 100% on healthcare or health which I believe is the more important right then availability of services. I think the actual health and capacity for participation themselves are the things that people are entitled to. But I asked the question where do we stand with regards to purposeful vocation as a human right? If you believe Maslow's ideas then this is just the next level up from housing and health. You are entitled to the opportunity to have something purposeful and impactful to do with your time. I think just tangentially, one of our big failings as a system is our capacity to offer these potentials for impact to individuals with disabilities and I think as therapists we have some responsibility to advocate for this. We learn all about the ICF model and impairments in the functional participation that go along with them and we need to advocate that if we believe that purposeful work is a right for all, that this means something for everybody and that the opportunity or the job might look very different but that if we think we're entitled to this, so is everybody else. So there are many variables to satisfaction in this system. Absence is some of the things we've talked about already, like control, esteem, sufficient connections to others or visibility of the outcomes that we're helping patients achieve. And some are not inherent to these jobs. I mean we'll all have satisfying jobs that otherwise have demanding schedules or long hours or challenging work environments. A hospital's not a relaxing place, I'm sure home health care's stressful in its own ways. Some of these inherent barriers that were made much worse by our current healthcare climate and this is where we need to focus our attentions I believe. So healthcare right now, certainly

there's a large focus on revenue and that leads to mismatched incentive. So the thing that is best for a patient might be different than the thing that's best for a hospital which is almost certainly different then the thing that's best for the nation's healthcare system. As a culture we have this emphasis on passive solutions. People come in with a problem, they wanna leave with an answer to it and we have this short term focus which is a combination of those two, of our mismatched incentives and our emphasis on passive solutions. There are a number of barriers which are shared in healthcare by all professions. Generally the total burden of clerical work, I summarize that by saying EMR, the electronic medical record but really it's all clerical organization type work is a barrier to really impactful purpose in the healthcare setting. Workload and staffing. These are problems we see in all disciplines. Certainly rehab, definitely nursing. Productivity is something that, I think the discussion about is improving but it's still widely used across all settings. I'm sure not the least in out patient, and we got the self limiting system. So again, many of these are ubiquitous to healthcare jobs. We all share this common experience I think, despite growing sentiment that productivity doesn't make a lot of sense that we still use it and especially is not the best thing for conservative professions. So jobs that would be very meaningful in a system that worked perfectly can still be unfulfilling when these barriers come up from the system and prevent our patients from realizing the outcomes that they should and prevent us from getting the most for our effort and time that we invest in patients care. So, the system itself exists in general to facilitate us to provide good care, but we're at a point in my view where the system is the biggest barrier to doing the work that we need and so to become satisfied we need to engage with the system, see the change that makes sense to us and then advocate for that. And then there are barriers that are unique to hospital PTs.

So, all of those which I just outlined but then on top of that our systems bias towards passive solutions makes it really under value to be a PT in a hospital right now. It's something where patients are gonna get out the effort, something in proportion to the effort they put in. There are still lingering misperceptions and I'm sure will be for some time about physical therapists education and skill in the setting of a changing scope and evolving practice act. So in terms to advance a measurement of satisfaction and burnout, much literature uses this Maslach Burnout Inventory which is something if you're looking to measure burnout directly is validated for that but it doesn't measure satisfaction, and I think your goals in your organization will, should dictate your management, or excuse me, your measurement strategy. And knowing ahead of time before you start to make a plan for improving satisfaction in your organization, what information will help you understand the problems and effectiveness of your solutions that'll help dictate what you use to measure. There is limited data about satisfaction and burnout among the rehab professions. Our work as I mentioned I think is incredibly interpersonal. It should be the most rewarding work there is. It's in general involves more face time with patients than many other healthcare professions but it's unfortunately, it's uniquely difficult to analyze quality rehab work from documentation alone and there are a lot of factors contributing to that. There is some literature comparing physicians with other healthcare providers with non MD doctoral degrees.

So this could be any professionals. It could be pharmacists with doctor of pharmacy, it could be PTs, could be doctors of nursing practice. There is nothing specifically that I came across in my literature review about PT compared to other professions but certainly the barriers that we might experience are, I think we share all the common barriers with our professions and then have some unique barriers of our own on top of that. So I posed this question on Twitter. I think Twitter's this great way to communicate professional topics like this. I asked, "What does your highest impact time look like "for people working in acute hospital PT? "The thing that you really set out to do "and how much that means to you. "How much of your week do you spend doing that?" And very few are spending half or more of their time doing things that they view as highly impactful. And so there is opacity of data about this I'm going to ask you all now to answer a few survey questions to see where we are in this regard. And I'll give a moment to answer that. All right, thanks to everyone who voted. So, I think the results should be available for everyone to see. A little better than the Twitter poll but you can see that you'd like these numbers to be higher. Only less than 6% of people spending more than 75% of their time on high impact work. About a third spending half or more of their time. So that's good but certainly should be better. I think this is in terms of complexity a relatively easy fix in our system and people should be able to feel like they're spending a lot of their time on high impact work. I don't think if we presented this poll to other healthcare professionals the results would be radically different but I think everyone's answers should be higher than this.

So I've got another survey question. There are a few here. So of your patient encounters during a day or a week, how many of those have you chosen for the reason that they help patients? And this maybe is a different question for the outpatient setting then it is for acute PT or home health or certainly SNF, but it's an element of autonomy and it's connecting your decision making with things that will help patients the most. So I'll give another minute for this question. All right great. Thanks everyone who voted. So, good. A high degree of choice it looks like in terms of choosing who people are working with. Certainly a different phenomenon in the hospital setting then outpatient or other settings but an important piece of satisfaction definitely. So a third question. How often can you complete, and this is one that I presented with the hospital PT setting in mind but, certainly I think this applies SNF and home care too. How often can you complete follow up PT treatments? Ignore the in the hospital part there. In your setting with the frequency and duration that you would choose absent time constraints. So maybe when you make this decision you have evidence based frequency in mind and you wanna be able to see your patients every other day in the home care setting for example. Or maybe you don't feel that you're able to meet the frequency you'd like or maybe you have to meet a frequency greater than what you like if that's the administrator pressure from your setting. So just, I'll give you another moment to vote there. Good. I'll leave it open for a second but definitely this is higher than I expected and I'm really glad to see that. So more than half by a good margin of clinicians are able to do their followup PT treatments with their frequency that they want and there's not a huge amount of outpatient PTs listening right now. There are definitely some but it's not like a group where the majority is outpatient and getting the frequency you want

is kinda built into expectations. This is a group with plenty of home health, SNF and hospital PT providers. All right, a couple more questions. So, in terms of contributing to differential diagnosis, and again I think this applies to any setting but if you observe findings potentially consistent with a problem that hasn't been identified yet, does your communication whether it's the physician or the rest of the care team result in data testing or diagnostic workup or do you feel like this is something that's not listened to as often as it should be? This, I can speak for myself in this regard. I think, I've worked in two different, one acute hospital, one acute rehab and have been fortunate that the cultures of those environments has been one where therapists input is definitely respected and appreciated and it's never felt like a big effort to try to communicate something that I think is important, but I have heard stories about settings where writers have really good input to offer and they don't feel like that is listened to as much as they'd expect. So I think this is another really important piece of satisfaction in terms of contributing to differential diagnosis in any setting. Good. And it seems like very often among responses here there's certainly some saying relatively low frequency, but many saying there's decent frequency with which there input is listened to and respected.

So, one last question here. Talking about the importance about what we do with the time we spend charting. So how often do you believe that your peers in your setting or in other care settings, access and use the information you document in your valid treatment notes? And certainly if you're spending, if you're asked to spend a lotta time charting, it's not a satisfying experience to feel like no one's gonna read the things you write and this is what we hear often I think from nurses who have to complete these long assessments with lots of check boxes who feel like no one ever goes to read the information that they write and that strikes me as an easy to fix, large source of dissatisfaction in our system. Kinda uniform responses there. Some with low frequency, utilization that information, some with high frequency, plenty in the middle. Okay. Good. Thanks for answering. I'm gonna move along. So talking a little more about those barriers. So, as I mentioned I think that PTs encounter the same barriers as other healthcare professionals, and on top of that a system which works entirely in opposition to the strengths of our professions beliefs meaning we focus on passive solutions, we say we emphasize prevention but we don't reimburse in a way that really enables systems to focus on prevention. But we also have so much going for us. I think if we can effect system change or if it happens over time, we are gonna represent exceptional value to our patients, and certainly to hospital systems in the larger healthcare system every single day. I don't view this as the same message that we're underpaid. I think we're just very valuable to what patients need right now and to where our system's deficiencies are. I think we're compensating financially in one way in that we derive satisfaction in our work but that there are so many job in our economy and culture right now where people are better compensated but much less satisfied and so we have this kind of paradoxical situation where if you're just graduating from college and you're kinda deciding what direction you wanna go in with your career, you have to potentially make this choice between satisfaction and compensation and that seems so inverted to me but yet it seemed so obvious among especially education and

healthcare right now. So a little more root cause analysis about dissatisfaction. What can cause dissatisfaction in work? As I mentioned I think volume is a contributing factor but that volume alone is not gonna make us unsatisfied. I think how we perceive the importance of our work is a big, big factor. If we think the things that we're asked to do are unimportant or they don't align with our values, it's difficult to be satisfied. Certainly autonomy if we feel like someone else is dictating what we do and when, that will be less satisfying then being empowered to make those decisions on our own, and the potential for impact. If we feel like there's great potential to make big impact for our patients, we're gonna be satisfied with what we're doing. I think no matter what if we think that what we're gonna do means very little to our patients, for example helping to make recommendations to a patient who has no safe environment to be discharged to then we're gonna feel like we're working against the system, not because the patient's needs, our potential for impact is low. We're not gonna be satisfied. And so I'll explore each of these factors individually.

So, a large volume of work, I think it can be stressful and tiresome and it can be challenging but for the reasons I mentioned I don't think we're gonna be burnt out based on volume alone. I think as long as the work we're doing is important we're gonna feel good about what we're doing. So, we're gonna be satisfied by the things that we view as impactful. Work that challenges us to practice at a high level and to learn and develop new skills and to do work that nobody else can do in the same way as we could as well as work done at the right time instead of being done too late to really make an impact for patients. Appropriate autonomy is satisfying and I use this word appropriate intentionally. Sometimes total autonomy is the right thing and sometimes it's really not. If we are a hospital and we empower our clinicians to make total independent judgment and that's not really the right thing, then we're signaling to them, make whatever judgment you want. We don't really care about the result whether that means we don't really care about the outcome for patients or we think what we do is so unimportant, we are sending the wrong message if we provide two much autonomy too. And so there is definitely a right amount. It's different in every setting and it can be too hard and too low I think for any profession and in any setting. Sometimes complete collaboration is right. Sometimes we do wanna be directed closely to do what we're doing and sometimes we don't. And so potential for impact. Low impact work is just not gonna be satisfying even if we have lots of time to do it and think about it and see it clearly, if it's not gonna make a big difference, we're not gonna be very happy doing it and it's tough to invest a lot of time and effort if the tasks we're asked to do are just unimportant and so I ask why we'd allow ourselves to spend our valuable time which could be used helping patients of low impact work. And so this idea is mine, this is my opinion about looking at burnout. These are all factors. None of them alone is gonna cause burnout but when they're all different a little bit from where they should be, we're gonna have this problem. So, if we have low impact and low autonomy and low importance over a high volume of work, we're gonna have low satisfaction and vice versa. If we have a small volume of high impact work, I think we're gonna be very satisfied with our opportunity to do that and to do what we need. So, I'm just gonna compare two jobs. Again, I developed this with the hospital setting in

mind but I think the principles will apply equally well to inpatient, outpatient, rehab, hospital. If you're in a busy hospital with an emphasis on getting patients out the door, and have a system where whether physicians or case mangers or anyone, not a therapist dictates how and when PTA encounters work, I think that that creates the potential for immense dissatisfaction especially in a culture where organizational values revolve around productivity even when PT evaluation isn't something that contributes to reimbursement directly we still wanna see that our staff are doing a lot of the job we're asking them to do and so we still use productivity, whereas if you had the same hospital with the same staffing that instead adopted the organizational commitment to care quality and empowered and trusted your rehab staff to prioritize the case load in a way that's best for patients, I think you're gonna have staff that are very satisfied. I think managers in a lotta settings understand that productivity's not the right metric and I think this is especially true in the hospital and becoming increasingly so, but we still use it because it's very difficult to come up with an alternative metric and connect that to value. So I think that workload and staffing certainly will influence satisfaction but I don't think they're major factors. I think they're relatively minor and I think the organizational culture and opportunity for growth and impact are the really big things. Being able to help people solve their problems and see that that's what you're actually doing with your time and effort.

So, productivity is not a problem unique by any means to hospitals or to physical therapy. It's a problem pervasive in healthcare. It's, our focus on it limits our face time with patients. It limits our capacity to do the thing that we actually set out to do in many cases. It is negatively correlated in literature with self, excuse me, efficacy. So if you are highly productive, that doesn't mean necessarily that you feel ineffective in what you're doing but if you're in a culture that pressures you to be highly productive your opportunity to experience high self efficacy is reduced. Productivity is not the right metric for acute care PT. It's not meaningless but it's not the way we should be looking at and framing what we're doing in that setting I believe. But it is very common in hospital PT and so our work's exceptionally complicated. I think for any healthcare professional, it's hard to separate out what people are doing and look at the value of it, especially in the hospital setting where so many of the effects of good effort and work happened down stream after discharge months later preventing the conditioning in a patient. It's very difficult to analyze in particular what we're doing in rehab but there are good alternatives to productivity and I'm gonna outline a few of those. Some that are discussed in literature are use of the AM-PAC Six Clicks which is if you're not familiar with that tool, just a six questions assessment of how much help a patient needs with each type of mobility. This has been used in literature to demonstrate that therapists are working with patients who have more functional limitations and the idea being if you improve all your processes and your therapists are working on average with a patient who requires a certain amount of assistance, as you weed out the easier work that could be done by anybody, your therapist will on average be working with patients who require a greater degree of assistance and that doesn't directly mean you're doing more impactful or important work but it is a proxy for that. If you're seeing people who have more physical impairments, that probably means that you're seeing people who

you can benefit more with PT treatment. Follow up treatments in the hospital setting and in other settings can be one way to measure this by proxy as well. If you're in a setting where you're not able to do followup treatments with patients, either in the hospital or home care with the frequency that you believe is appropriate, then you're not gonna be able to help those patients as much as you could. And so if you change your processes upstream and are able to do more followup treatments with patients, this should mean that you're able to do things in a way that is more effective. Discharge dispositions. If you're doing a large organizational change and your goal is to say, keep patients stronger while they're in the hospital, you should find that fewer patients are discharged to rehab because of deconditioning. Fewer patients are readmitted after they're discharged home because of deconditioning, and these changes won't come at the expense of one another. You should get better at all of these outcomes as you improve process change.

And then patient encounters. Some hospitals use just the number of patient encounters as a substitute for productivity. How many patients are you interacting with in some way, whether evaluating, you're treating, or reviewing the chart and seeing that they're not someone who's appropriate whether they're not ready or they're too independent for you to work with, this is something that is maybe a type of productivity but maybe a substitute for productivity depending on the setting. It's tough to make messages, especially the kinds you hear in mission and vision statements sorta mesh with what's actually happening. So, if you're part of a system that constantly says things like quality if our priority, but then at the same time forces you to focus on productivity and doesn't do the easy things that don't produce revenue, that are good for patients then they're demonstrating that they don't really believe that mission statement, that quality's a priority and so productivity I think has for a small relatively nocuous thing I think has done a lotta harm in healthcare and I think that at some point or another we're gonna swing totally back the other way away from productivity. And so along with that focus, I think our electronical medical record has framed the work that all healthcare professionals do in a certain way, namely one to revolve around billing and documentation. And we experience this definitely in rehab. I think physicians and nurses also experience this. Highly intellectual, challenging interpersonal work is becoming increasingly framed as task work and if you're a busy nurse and you have a buncha patients to do things with, no matter how well you were trained and how bright and dedicated you are to do great care, once you're that busy you start to view things as I know I have to do these tasks, I know I have to chart them in this way and that starts to frame your thinking and your planning and how you spend your time with your patients and it's, I think very unfortunate and it's, not only is it hurting patient outcomes, it's really taking from the people doing the care and the satisfaction that they're entitled to. So, the volume of the case load and the way we do the charting about it I think are conditioning us to think a certain way about the work that we do. This is my opinion. This is not a thing that, there's much or any literate about that I've seen but I think this seems pretty clear to me. I think that this is such a highly emphasized part of what we do, mostly because of how reimbursement revolves around it that it effects how we think and down the line how we act. So I'm gonna

return to this example. I think it summarizes the message I'm trying to make pretty completely. So a craftsman who makes something start to finish who shapes the materials and creates the finished product and sees his own skill and how he's, or she has developed in that finished product, they're gonna see that in their work and they're going to be satisfied. I think it's just inherently much more satisfying to see yourself in the work that you do. Whereas a node on an assembly line does not and I think that healthcare should be the furthest thing from employing nodes and assembly lines and using processes like that but unfortunately, our sorta short term financial focus in particular has created these situations and this is something that is discussed at length in literature, the phenomenon of existing in silos separate from one another. I mean PT at its fundamentals is this really great profession of understanding the whole person and synthesizing all this really complex and important knowledge where we learn microbiology, we look at labs for patients, we learn about body systems. We examine their specific impairments, we synthesize knowledge about disease states and what prognosis might be and then we evaluate the person themself and their functional capacity and then we apply that to how it might contribute to ability to participate in things that matter to the patient in the community.

And so we go from the tiniest scale all the way to this big broad inclusive scale and for us to be sorta shunted into this narrow isolated thing is the worst. I think that PTs deserve so much better than this and that we are at our best when we don't let that happen. I think we have so, so much to offer in that broad context. It doesn't make any sense to be the person that comes in and does this or does that or does the home care evaluation. We have so much to offer patients in the system and we need to advocate about that. So inequity. I brought up health equity earlier as something that's highly correlated with satisfaction. So, there are many types of inequity among healthcare workers. Age, gender, race are the ones that we all know about and no surprise there. These are types of inequity that should not exist, unfortunately do in some situations. And there are many others. There's unequal compensation, different amounts of experience, evolving professional scope, and there's knowledge and motivation. If you're someone who has got a lotta knowledge and is heavily motivated to apply that knowledge, my view is you just need to be totally empowered to do what you believe is right. If you are highly motivated and lacking in clinical knowledge, you can develop that knowledge. You can be trained and you're really valuable to your health system. If you have a lotta knowledge and are unmotivated, this I think signals that there's a problem with the system. It's just hard to imagine a situation where someone could pursue really lengthy complicated training and just be totally unmotivated to do that job. In cases where it does happen I view that as largely a systems problem. And then if you have employees who are unmotivated and unknowledgeable, I think you start by understanding what's important to them and helping them gain knowledge and more than likely as they learn new things they are going to find motivation to apply that knowledge. Inequity is more complicated in PT for a number of reasons. One being our changing education requirements. We went relatively quickly from a bachelor's degree to a master's to a clinical doctorate, and our practice scope has not really changed with those educational requirements. So you have this group who are all licensed to do

the same thing and people have different sometimes high specialization to do different things and this is an opportunity for inequity and its unfortunate how it is I think in these professions right now. It should be a continuum where everyone's always learning from each other. My perception is that the quick change in education has contributed a lot to inequity in this setting but I think it's something that the more we improve the more satisfied everyone's gonna be at every stage in their career. And so I'm gonna wrap up fundamentals of dissatisfaction just with this really great quote about chronic stress. So this came from this author who wrote this book about working a couple of really low wage jobs. She worked a fast food job and a couple other jobs. It talks about the chronic stress that those experiences created but I think what she summarizes here is just a great summary of the importance of dealing with dissatisfaction and stress promptly. So she says, "That chronic stress will destroy your body "like doing burnouts will destroy a rental car "that someone else is paying for. "It's a huge factor behind the epidemics of heart disease, "obesity, autoimmune disorders, depression, "anxiety and drug misuse that affect developed countries. "The diseases of civilization." And I think this is a really great point. I agree completely with what she says. So I'm gonna talk a bit about organizational strategy. I flipped the order. If you're looking at the course outline at all of individual and organizational strategies, this is to reflect my view that dissatisfaction is a systems problem to a much greater extent than it is an individual problem.

So we're gonna start here with this quote that, "Management's overall aim should be "to create a system in which everybody "may take joy in their work," and this, W. Edwards Deming is not a philosopher or a poet. He was a business guy, an improvement scientist who wrote and talked a lot about problems with systems and how they not only limit results that companies might achieve but how they make workers dissatisfied. And I think that this quote is not a new quote. It's so different in our culture in general but particularly within healthcare from what many leaders think and do. It's very difficult to separate I think good work from satisfying conditions in any sustainable way. If you want to have good work you have to have good conditions which means your culture. If you wanna have good culture you have to attract people who are willing to do good work, and that a system that lets good workers find joy and see joy in what they're doing is one that starts to meet that systems obligations to its customers or clients or patients and importantly to its workers. So I'm gonna give more background about why some of these strategies I think make the most sense, but we'll follow a lot of ideas from the field of improvement science. This is a slide that I try to work into any discussion when I can. The idea is that in healthcare right now, especially leaders are focused totally in outcomes but not always on the ones that matter to patients. As I discuss our system cares a lot, more than ever probably about the outcomes associated with reimbursement because of the current financial climate and so this demands unfortunately a short term focus to maintain financial competitiveness and I think that this perspective limits our system for being as good as it could or should be for patients. My view is that we get good outcomes from instituting good processes and that more importantly we get good processes by building good culture. If you can build a good culture in your organization you're starting an engine that

produces good results no matter what industry you're in. I'm gonna outline some strategies here and I think a big part is sorta, if you're an organization looking to build a good culture from scratch I think you need to pick one thing to be really good at and then to make it known and then to attract people who wanna do good work and sorta build this self perpetuating system from there. I don't think this is something that can be emulated. Either you're doing it legitimately or it's not happening and I think that this is where quality comes from in my view. So we have this big advantage. When I say culture before I get to it, what I mean is this sort of unspoken set of shared ways and values but in healthcare we have this really big advantage that most of the people working here did not choose it because they wanted something easy or they just wanted good compensation. Mostly healthcare has people who choose these jobs because we're compassionate, dedicated, motivated people, and I think that unfortunately the fact that we are so dedicated to what we're doing makes this tool that this ineffective system takes on us much larger than it would be if we were in a different setting. So what I mean is that to be a healthcare person and participate in the system right now, might even be more distressing than if we cared less then how the system was where we worked in a setting where we didn't care that much about the outcome. To me it's hard to believe that a healthcare system which views its employees as a cost liability or focuses on producing revenue is gonna somehow flip their views and maintain the right attitudes about patients, about who they are and what we owe to them. My opinion about this is that healthcare really just is not a business. It doesn't make sense to frame healthcare as a business. That's a more complicated statement definitely then it sounds but healthcare to me is totally not like any other insurer business. There are a number of things that leaders can do to work around these problems.

So, Deming's statement that I mentioned a moment ago that joy in work is a right, I think is the long and short of something that we need to work towards and that leaders have a responsibility to facilitate that right. There are a number of things that leaders can do. Acknowledging limitations is certainly an important step. The idea that failure is a learning opportunity is a cultural value that will start towards quality work that people will be satisfied with in the development of a just culture which is one that adopts the mindset that care failures are very often systems problems rather than individual problems. These are the first steps towards developing a work culture where people can be very satisfied with the work that they're doing. So Deming's idea was that management needs to remove barriers that rob workers of the right to pride of workmanship and thereby the joy that they should experience in their work. Deming posited that we need to harness the power of intrinsic motivation rather than try to motivate top down by incentives, to work always towards improvement among individuals and also among our organization. That we need to remove waste which I think is more timely than ever in healthcare right now and to cultivate a culture which collaborates between disciplines. He descried worker's rights that include the opportunity to do good work, to see the connection between their time and effort invested in its results and to remove numerical work quotas which paradoxically did more harm than motivated people to do good work. So removing those quotas like

productivity, Deming put forth is a big step towards cultivating satisfaction in work. Antonovsky's a name I wanted to bring up here. He was a medical sociologist who took this inverse perspective about the idea of disease in general. So his big message through his work was that health is something totally different then the absence of disease. And so when we talk about health as making a diagnosis and then treating that condition, that's just the completely inverted perspective. His message was that health is a sense that life is comprehensible, manageable and meaningful and this removal of boundary between healthy and sick I think is totally endogenous to the point I'm trying to make about burnout and satisfaction but also it's important to understand that everything happens on a continuum. There's not this discreet barrier between two different states. The other important point that he makes here is the sense that things are meaningful. So if we aren't creating opportunities for meaningful work for our clinical people and then making the results of their great work clear to them then we won't be as successful as we could be in helping them be satisfied in their work. So Peter Senge is another improvement scientist who contributed a lot of really valuable ideas to this area. His main idea is the idea that companies, healthcare or not need to become learning organizations and this means sort of pulling away from quick fixes in favor of sustainable solutions that are arrived at by actually identifying the approximate causes of our problems. He put forth the idea that this gap, this time gap between cause and effect especially in the healthcare setting necessitates a longer term, broader systems view. He described the learning organization as people working together at their best, continually improving. The antitheses of which is total control over workers.

So empowering people are motivated to do good work. When our autonomy is low and our sense of self efficacy is lower than it should be, we're not gonna be satisfied. Senge further expanded the learning organization to prioritize the development of people as something on an equal tier with financial success. His message was that compliance is never the desired behavior. You can put forth protocols or ideas or different ways to do things but you always wanna have people know when it makes the most sense to break the rules. If it's gonna be in a patients best interest to do something different than a protocol, you need to empower them to do that and that's if you already have healthy organizational culture and you already hire and train and attract people who are bright and motivated to good work, then you build a culture in which you can do that. He discussed also the concept of a shared vision which is this not just written and printed on the ID badge but this legitimately shared common belief about what we're here to do. It's much more than just a vision statement. It's an actual belief. It's this unspoken understanding, common values that drive what we do, how we think about it, the ways in which we go about helping patients achieve outcomes. And then Senge also had this idea of even really well meaning interventions producing response is different than what was intended or sometimes totally negating the benefit of any intervention at all. And so the example to me is in the book "Animal Farm" there's a horse that solves all the problems of the animals by saying, "I'll just work harder. "I will, instead of meeting the problem at its cause, "I'll just work harder and I'll get it done." And that enables the delay of the solution and the real problem. And so

we have this point in healthcare where the strengths of our great people is that they're really motivated to do good work and will work really hard and do a lot of this at the cost of their own well being is actually, it may be actually enabling the later absence of the real solutions that are system needs. And then one other idea from Senge is the idea of personal mastery. It's that to be satisfied in a career you need to be committed to what you're doing and believe in its importance to exercise a high degree of responsibility. So whether as PTs this means doing evidence based practice and knowing that I was hired at this facility, as a PT with a license and what that means to me is I have to do the scope of PT at a high level, if you're able to do that then you're gonna find satisfaction in your work. Initiative. The empowerment for individuals to change things that need to be changed or to apply their skills in a way that makes the most sense is of course highly correlated with satisfaction as well. But his important idea is that empowering people before or in absence of this shared vision in aligned goals can do more harm than good. And so you need to work in several directions at once, but you need to be sure you're hiring and training really bright motivated people if you're gonna ask them to know when to ignore protocols and policies that you set. And so one last note on development in the workforce. I'm gonna read another quote here which I think summarizes the message really well. It's that, "Being truly committed "to growing people is an act of faith. "You have to believe in your heart "that people want to pursue a vision that matters, "that they wanna contribute and be responsible for results "and that they are willing to look "at short falls in their own behavior "and correct problems whenever they're able. "These beliefs are not easy for control oriented managers "and that is why there remains a big gap "between the talk and the walk regarding developing people."

And so the idea of control from a management perspective is definitely something that's repeated throughout literature and throughout this presentation even. If you are, there are times where it's the approach that's needed. The best thing is to try to move away from that by developing, training people and building the right culture in your organization if you're in a situation where a high degree of management control is needed or what's used, there are things that need to be changed. That's kind the long and short of it but at the same time even if you recognize that, you can't in absence of other culture change just remove that control, that also does more harm than good. It's understanding what the problems are, understanding their nuances and then deciding what to do from there. So, in terms of making organizational change and making a plan, step one to me is always needs assessment. Understanding where you're at in terms of burnout or satisfaction. Inventory's do exist. The Maslach Burnout Inventory is one that I mentioned, but I think that valuable information, really valuable information can be obtained from a basic survey. Depends on the setting, depends on the type of department, depends on the size of the department. The most important point in my mind is that if you're going to solicit input from a work force that are potentially dissatisfied, you have to be prepared to do something with it. If you solicit feedback and then fail to put it into action, staff feel that they're not listened to or that they were heard and ignored and the worse thing you can do is to ask for this input and then not be ready to do anything with it. My view is that the best way to obtain this information

is to just make a basic survey. I think anonymous surveys are very helpful if you want frank, honest input about this information but I think just a very basic anonymous survey is a really good starting point for understanding where your workforce are at as long as you've done some planning ahead of time. You feel prepared to put some of the information that you get into action. It's important with any needs assessment in healthcare or otherwise not to assume anything. Even if you feel like the cause problems and their solutions are all very obvious, don't assume anything. You can always learn a lot from needs assessments. A likert scale, the one through five point agree to disagree it is, can be very useful especially if you plan to reassess after interventions or culture change or any projects. If you're gonna reassess and wanna know how effective what you're doing is, a likert scale's really useful and it becomes very useful if you intend down the line to correlate your culture change with any type of value metric which is unfortunately something that's demanded in our healthcare system.

So focused on revenue. But again the needs assessment is an effective way to solicit frank, honest input. It can be a really engaging start for employees to feel like they have some agency, some control over decision making that's happening. This itself can be an intervention to improve satisfaction if you're prepared to put input into action. If you ask people what they think and what they believe should be done, you're already starting to work towards better satisfaction by letting people give their input and feel heard. The things that I view and certainly that the institute for healthcare improvement outline has important information for needs assessment are to know that as a clinical person, as frontline staff the one hands on, taking care of patients, what matters to you? And when we do things right, what does that look like? When we spend a day full of high level care, full of high impact time, full of things that really matter to patients, what exactly does that day look like? And what stops us from doing that? What are the things getting in the way? Is it that we're spending too much clerical time? We're spending too much time planning? We're not spending enough time planning and not able to identify the work that we should be doing promptly? What is the thing that's limiting us from spending that really high impact time? And taking this input and feedback and putting it into change can be something immediate and direct. It can be something that requires bigger process change, but once you ask this then you start to answer those questions. So feedback, we learned in PT school is critical for improvement of any type. We give it to our patients, we tell people how they're doing, we tell them about the ways that they're doing things, but in healthcare and I think in most professions peer feedback is really lacking. We don't provide it to each other, we don't solicit it from each other. Certainly not enough to grow continuously and other professions have some really structured mentorship experiences. I know PTs have residencies and fellowships, but we're definitely weaker in this regard than for example nurses or physicians. If you're a nurse you're gonna have your clinical rotations in school where you're gonna have structured feedback. You're gonna have a preceptorship when you start a new job and as you change settings you're gonna have more structured feedback with sort of line by line scheduled information. And if you're a physician I don't know that much about their training but I know that they have I'm

sure an even greater degree of that. And in PTs I mean, we have our clinical rotations and then everyone in healthcare has probably a scheduled assessment where their manager might go over some things with them. But it's definitely lacking. I think this is true in all settings and if you're working towards specialist certification, like you're an NCS, you're gonna become a brain injury specialist or something like that, then you can find programs like this but really even if you're a generalist, if you're a therapist who wants to just maintain and develop sorta baseline PT skills and be able to cover a broader range, that's something that can be developed. It shouldn't be that you're a generalist and so you're not gonna grow. There always needs to be growth and it's not always that easy to find as rehab staff I think for a number of reasons. Educational changes of course being one but just lack of structured experience I think definitely being another. And so there are many types of feedback definitely. As I've outlined I think there's a high degree of focus in our healthcare system on outcomes feedback but there's so many other types. Process feedback is the type linked to improve satisfaction. Talking about how we're doing things and why and I think what this signals, when we give more than just knowledge and results, when we give actual process feedback, we're signaling I think what you do is important, I think it's important enough to scrutinize it and to talk with you about how to improve it, and I recognize that it's something that can always be improved within and outside of rehab disciplines. This in my view process feedback is just a fundamental part of continuous improvement philosophy, regardless of the setting. Whether it's healthcare or not, I think we have this extra duty to do it in healthcare certainly. I think there's an argument to be made that as a worker having to see a manager, that produces agency itself. It helps you view yourself as part of an organization making decisions and that already promotes engagement and thereby satisfaction.

And I think failure to discuss how and why we do things like for example in the hospital, prioritize case load or how we choose who we see and when, I think that that signals that our employer doesn't necessarily view those decisions as important or impactful or as our work as something that matters enough and that's unfortunate, because I think if you talked to anybody they would agree yes, these things are important. They matter to patient outcomes, but the lack of this feedback and its provision definitely makes it seem like this work is viewed as not that important. You can bet for sure that if you're a surgeon and you're scheduling your time in the operating room a certain way that blocks or limits the number of procedures that can be done, you are gonna get feedback about that because everyone understands the importance of that decision, particularity as it relates to reimbursement. And so there's no argument that that is important but the fact that it's not provided in other healthcare areas to me is just giving up this really cheap and easy way to improve engagement and satisfaction and process. So peer groups are incredibly valuable. Mayo Clinic actually did a great study specifically about the value of peer groups. I think that anyone would agree, having time to reflect on cases with your peers with whom you work, or outside of your own department is something that's going to help you provide better care in the future and it's a mystery to me why in general in healthcare we don't schedule more time for this and I don't mean just rehab. I think that this is very

deficient everywhere and certainly teaching centers have conferences on even relatively frequent, on a regularly, excuse me relatively frequent basis but this is such a valuable thing relative to what it costs that I think the frequency is way lower than it should be. There are a lot of ways I view this as being actionable. Certainly within department but also interdisciplinary discussions are super valuable. Social media is a tool we have now to do things like this. Case studies, written and verbal and practice clinical skills I think are all really easy high impact ways to do better work and be satisfied. So the Mayo Clinic study demonstrated a reduction in emotional exhaustion, overall burnout and depersonalization of work just from getting together one hour to talk about cases. So not only did it help people feel more confident about their clinical decisions, it improves the way they felt about the work they did and the cost of this intervention is known. I mean it's whatever it cost that staff to meet for that of time. It's relatively low. But no matter how skilled we become at reflection, if we don't build in time to do it it doesn't matter how good we're gonna be at it. We need to dedicate time to this. Compared to what it costs it's so so valuable. And so developing a savings model for demonstrating that benefit becomes the hard part and I am gonna discuss that more because I think that's the challenging part of this work both inside and outside of rehab. But in general, I think that building a culture of quality becomes a virtuous cycle. So something that as you get better at it, the pace of improvement accelerates.

So as we build a good culture, we're gonna attract bright and dedicated workers to come work within that culture. Those workers are gonna do quality work for patients or whatever the industry is and that's gonna attract more bright and dedicated workers. As long as we keep making it known this is what we're doing and we're not just on this list of best facilities or anything, we are actually doing things that matter to patients, you will start this engine towards quality that once it's got momentum can take care of itself and I think this is what many academic centers and teaching centers do. They just start the engine, they build a great culture and there's some maintenance involved but for the most part it exists. People will come to it just to come to it and this is the long and short of how to create a competitive organization in my view. And so once we are developing that culture, it's important to communicate that culture. There are a lot of ways to go about this. Professional publication is one. I think mainstream media is also a valuable one. People even within healthcare are much more easily moved by a persuasive case study and seeing one patient that was really positively effective, than even a mountain of data. So publication of all types. Conferences are good way to communicate to people within your profession and then certainly public data about what you're doing, how it's helping your community. The more you can disseminate I think the better off you're gonna be. And so you hear a lot of mission statements, that combine the same sorta ideas in different combinations. Some will emphasize employee health. Some will emphasize teaching and learning. Some will emphasize access to only certain populations, strengthen the communities around them. Everyone sorta picks from what seems to be the most needed thing and unfortunately the actions don't always match the mission statement and this is just a problem in healthcare right now I think but if we say our goal is to serve this underserved

population and then we go and prioritize things based on what produces the most revenue, it creates this dissonance that's unfortunate and I think that there's no reason that facilities can't do both. Certainly there is a culture where finances are a big part of what all organizations do, but at the same time all the things that healthcare facilities across the board fail at are typically the cheap and easy things with no reimbursement attached to them. So, we're gonna move on to strategies for individuals. There are a few different things here but again the, my view, the long and short of it is the way we fix these problems are focusing on organizational strategies first. Individual self care is important but it's not the way you find satisfaction in the work that you do. It may help you maintain balance and work along a satisfied career but the time you spend at work is gonna be, the way you feel about that is gonna be dictated by what you're doing at work. So start with a quote. "The place to improve the world "is first in one's own and head and hands "and then work outward from there. But I think at the very least we can work from two directions at once. We can be working on improving our organizations. We can at the same time be working on improving self care. No reason we can't start one and also work on the other. Some strategies for individuals. Like I said, not solutions to the problems at the root of dissatisfaction but still important and they can address our immediate needs as we work on longer sustainable change within organizations. Literature definitely support that whatever term we're using, burnout, dissatisfaction, physical or emotional fatigue effect job performance. That is beyond doubt. But in healthcare we work long hours and busy shifts anyway. And this is kinda an analog to what I mentioned a moment ago that we're saying one thing and then with our actions demonstrating something else. We're saying that either we don't believe that or we just think we're above it because we're healthcare workers and we don't need to pay any mind to self care and we need to I think practice what we're preaching.

So, self assessment. The first step towards solving a problem, you can say it's acknowledging the problem exists or you can say understanding it fully. It's knowing that it's there and seeing clearly why. But it's very difficult to view our own engagement and satisfaction with our jobs objectively. We've been doing them for awhile in many cases and we are used to thinking about them in the way that we do and there's a certain unfortunate belief that we don't deserve to be satisfied all the time, that things should be difficult and tiresome but I couldn't disagree more with that belief. We deserve every day to be really satisfied in what we're doing. So sometimes it's just a matter of recalibrating our own expectations, pausing, examining how we feel about what we're doing and making sure that our expectations are accurate. Before I go any further I'm gonna just reconsider the idea that our profession, PT in particular espouses the ideas of prevention and of a person in their illness or injury or limitation existing in this broad psycho socio context. But as I mentioned we don't always practice these ideas ourselves. So one way, the one I advocated in my response to Dr. Gorman was that we, we're gonna be satisfied if we advance our practice, if we do things that are challenging and impactful and more than the basic stuff that many other people could do. This could mean specialization development of highly refine their clinical skills. It could be developing programs in a community in a hospital in the healthcare system. It

could be seeking publication, getting a message that we think makes sense and trying to share it and certainly hearing feedback when it isn't the thing that not most of our profession feel. I think lifelong learning is an important part of any industry, that in healthcare we have a duty to do it. It's always exciting to be involved in courses. Certifications are one thing but as long as we're learning and improving our usefulness to the people with whom we engage, I think we're gonna be more satisfied. Mentored experience as I mentioned is something that's deficient. I think there are at any stage in a career opportunities for mentored experiences whether as the mentor or mentee and I think that this is something that's highly correlated with satisfaction and perceived impact in work. New collaborations. Collaborations with other departments, with other facilities, with other segments of the population depending on the setting that we live in, these are things that will challenge our perspectives and force us to look at familiar problems in new ways and I think that always challenging our routine reasoning is an important part of lifelong development and growth.

So I'm gonna talk a little bit about presence. This to me, the idea that we're doing one thing at a time even if it's something mundane that we don't enjoy like charting, when we're doing something that's what we're doing. In the context of one patient engagement, this means being prepared to offer all we can. This means being totally focused on what we're doing, on doing just one thing at a time whether it's something that we enjoy a lot and view as highly impactful, or that we look forward to getting over with and view as not especially useful, we need to be doing the thing that we're doing. This is an important part of satisfaction in all areas. If we are, while we're charting kinda thinking of something else and looking forward to getting it over with then we're gonna allow that mindset to creep into the things that we enjoy and view as important. And so it's always, it's important to set these barriers and to always do the one thing that you're doing and have that be it. Mindfulness is one of my favorite interventions and I gotta admit that I was biased towards mindfulness based stressed reduction before I knew about the robust body of evidence for it. I think this is a great thing. It sorta fits as an analog to many of the ideas that PT espouses that there's a lotta really easy cheap cost effective stuff and we will get out of it what we put into it and this is kind of a really great encapsulation of that idea. So mindfulness based stress reduction is the idea of acknowledging your thoughts, conscious and unconscious and just observing them and allowing them to pass reflective meditation that facilitates clear thinking and allows us to observe thoughts and biases that maybe we have suppressed or not noticed when we're busy. It is separate from culture, other beliefs. Not part of religion by any means and there's a ton of evidence for mindfulness based stress reduction among patients with anxiety and depression and a number of other problems. But also good evidence about mindfulness based stress reduction for healthcare workers. So I'm gonna discuss that a little bit here. But the fundamental idea about it is this pursuit of disengagement from attachment and bias and as I mentioned a robust body of evidence for patients. Reduce cortisol, reduce anxiety, reduce depression, reduce physical markers of what we typically view as biomedical problems. It's a really, really great and interesting field. This is mostly done by Jon Kabat-Zinn who's a researcher at the University of Massachusetts Medical Center but I think has widely spanning

work at this point. He has researched mindfulness based stress reduction for healthcare workers particularly with a focus on reduction of stressing emotional states and these interventions, cheap, easy interventions have demonstrated better work engagement job satisfaction and reduce psychological distress and anxiety. He's got a protocol. This is just listed straight from the literature. It's an involved thing. You can see the seven hour day of silence and then maintenance meditation practice over eight weeks. But the idea is that if we're committed to something we're committed to doing it. We need to fully be in it and invest in a certain amount of time and then have this maintenance period after learning the skills and I think it's a really valuable thing with a lotta data behind it and it cost nothing. I think that this is something that will only be more increasingly utilized inside and outside of healthcare. So, if this were for example a program that you wanted to implement in your organization, there's the initial training for the intervention measurement baseline and post intervention measurement and then making sure that you can commit to time and daily practice and I feel that this is something that is relatively easy to attach to a cost. If you already have data in mind about the cost of dissatisfaction and I'll outline what that might be in a moment, then you can very easily say okay, I spent X amount of time on this and it was this valuable towards these metrics. This is I think an easy and valuable way to implement and element of self care.

So to speak a little bit about action in terms of organizational change, I mentioned that change should happen from two directions at once. I think it needs to happen as a organizational change and also can happen from within in terms of emphasis on self care. And the difficult part whether we're in rehab or we're outside of rehab, in healthcare right now we need demonstrate the value of what we're doing concretely and this in my view is the hard part of this work. Everything else is maybe a little complicated to understand but this is the hard part to actually do. It sometimes requires creativity in terms of metrics and cost modeling, but it certainly can be done. And so I think to me it makes more sense to talk about improving satisfaction than it does limiting burnout but I know that one way to make these easy is to partner with your human resources department. They're already measuring some metrics. There are things that they care about already. There are things that they're already focused on improving. It makes sense to partner with this partner organization before you think about what you wanna measure. We did a program at our hospital where we were looking to prove the, or we're still doing a program I should say that can improve the mobility of hospital patients. It had a few metrics in mind and then it turned out that, we talked to our readmissions from home and discharged us to rehab and then it turned out what people really cared about within the organization was length of stay, how it effected length of stay and it was only a modest change but people already were interested in measuring that and so it was easier to talk about, instead of talking about the importance of these other metrics it's easier to just emphasize the one that people already cared about measuring and I think that's an important lesson in developing and programs definitely. So partnering with HR can save you a lot of time and effort. So demonstrating value programs. You an look at how care quality is improved. You can look at organizational performance through whatever metrics you're already tracking.

You can certainly look at work attendance. There's a high correlation between burnout dissatisfaction and reduced work attendance. All of these things will improve as satisfaction improves. You'll have better quality, a better organization performance and you'll have better work attendance and your employee turn over will decrease. So in terms of thinking specifically about modeling cost savings, employee retention, there, excuse me. There are costs associated with recruiting people in different jobs in literature. The estimated cost for recruiting a new physician is as much as a million dollars. I would say soliciting impact, if you partner with HR about what they perceive these costs to be is the easiest and quickest way towards modeling a cost savings program. If you can improve employee retention for whatever staff and there's already a cost in mind of pursuing new staff, then you can very easily come up with a cost model and even if the changes are modest in terms of employer retention, that cost of the intervention is so low that it's gonna be a very valuable program and it's gonna make people more satisfied. And when workers are more satisfied patients are more satisfied. They receive better care that they're more happy with. Satisfaction is kind of, patient satisfaction is kind of an iffy metric in healthcare right now for a number of reasons. Whether or not it makes sense to measure that I think is certainly up for debate but it is something that has been demonstrated to improve with worker satisfaction.

And then work quality. This is something that can be measured in many different ways, so I'll discuss a few here. So in the hospital setting as a PT, you can stratify the quality of the work you're doing a number of different ways. You can reduce low value referrals. You can stop doing the PT consults that don't really need to be done because patients are independent or could be mobilized by anybody. You can look at the improvements in your, as I mentioned in the beginning your impact Six Flick scores that you're working with patients with more impairments. You can look in the frequency or follow up treatments, reduction, readmissions, improvement of proportion of patients discharged to rehab. This is different by setting certainly. This is just with a hospital in mind, but there are many, many ways to slice this. If you already have quality metrics in mind think about satisfaction might improve those and then go from there. This is an interesting study about burnout and medical errors among surgeons. The conclusion I think is up for discussin definitely but the idea is that medical errors, major medical errors reported by surgeons are strongly related to their degree of burnout and their mental quality of life. And more literature is needed to determine how to reduce surgeon distress and how to support surgeons when errors occur. And you have to think that there's some kind of relationship between the type of people who report burnout and the type of people who, these are self reported errors. So the type of people who self report errors, but this is something with a huge cost associated with it and if you can improve satisfaction among workers at any level, you are going to be able to drive a meaningful model of cost savings and this is just one I think highly visible large example of that. So in summary I think that the value of joy and satisfaction like PT is much larger than we tend to realize. I think it's something deficient and extremely important in healthcare and in every industry and a very useful thing to focus on. I think that our role as clinical people is to put forth some degree of

effort to connect the dots between being satisfied ourselves and taking better care of our patients and doing things that are better for our systems. I think that this just is part of our responsibility. If we are saying we wanna be empowered to do more meaningful work that makes us feel better then we need to put forth a little bit of effort to say this is how we're gonna do it and how we're gonna measure it. I think it makes a lot of sense to combine both subjective and objective measures. You can't get very far at cost modeling with subjective measures alone but certainly for something as individually focused as satisfaction, the subjective reports are critical as well. The cost of burnout when you get to the point of cost modeling, again the cost of turnover very high. It's certainly lower for rehab and nursing staff than they are for physicians but data about those do exist. The cost reported in labor reports of absenteeism are absurdly large and frankly almost definitely under reporter there as well. This is a huge, huge cost in our system and we sometimes miss categorize it as things like, there's a dollar amount attached to work missed to back pain. But the further you get especially if you have the knowledge and expertise of a PT you understand the relationship between mental well being and complicated things like chronic pain and there's enormous cost associated with absenteeism and burnout and dissatisfaction without a doubt and enormous contributor to that. Errors in healthcare I think are very difficult to attach a cost to. Their cost of that is almost certainly under report as well. I view error as any deviation from 100% perfect decision making. And so if an appropriate diagnosis is delayed, if an inadequate treatment is started, these are types of errors if not the flashy kind that our system measures now.

And so again if you can come up with a way or have a way already to track some errors, you can come up with a very meaningful number when you get to cost modeling and then productivity. You're probably already measuring productivity. You can, you're already tracking it. You can see how it improves in satisfaction. Maybe this provides a strong enough model for cost savings on its own. So in review, the sequence that makes the most sense to me is to assess your needs, organizationally and individually and then to decide on how you measure your baseline. Choose your interventions. I think there are a lot of really good inexpensive ones. And then develop cost models to use to demonstrate their value whether you're going to advocate for more time for a programs or you're gonna advocate for more resources, being able to bring forth effective cost models is the way to get resources to provide better patient care. Implementation of both individual level and group level programs certainly is the big part of any culture change especially one revolving around satisfaction. So many important things happen from organizational change but at the same time if you're gonna measure satisfaction doing something focused on self care certainly makes sense too. You need to commit to culture change. If it's gonna happen it has to be a top to bottom thing. You have to define what it means to you and it has to be something not superficial but really meaningful and important to patients and I think anything in healthcare provides an opportunity to learn a lot, whether we do something right and see what we can do differently next time or whether we don't need to change anything or whether we failed completely. There is always an opportunity to learn as long as we continue to reassess the effects of what we're doing, we will always keep

learning and always keep getting better and even if the biggest intervention you do is just adopting that mindset that we're gonna constantly reassess how we're doin', whether what we're doin' makes sense and learn from that information, you will improve the culture of your organization. Demonstrating the financial benefits certainly is the hard part in my view of this project. It's soft intervention not often viewed in a very scientific approach but there are great frameworks out there, certainly as IHI, white paper on joy is a really great starting point if you wanna work on organizational change. But you have to connect some dollar amount to the programs you wanna do if you wanna be able to keep doing what you're doing. Creative measurement of value is certainly an important part of that and in PT especially you have to be creative outside the box with measures you wanna use but the goal you should be working towards in my view is to build this, to start this engine. To build this self perpetuating cycle of good culture that attracts good people that do good work that attracts more good people and once you can get it started I think the pace with which you improve only accelerates. So, you can do this. You can. It's important to your patients, it's important to your workers, it's probably important to you. I love this picture. This to me summarizes the idea. In this one picture is everything you've ever felt stressed about or ever worried about or ever want to make better. It's all right here. It can feel overwhelming to have this complicated system and to have to attach dollar amounts to it and the stress of the huge enormous volume of work. It's all relatively small fries. You can do it.

And I've got some references here. So thank you so much for listening. I'd be more than happy to take some questions and see if I can answer anything for anybody. So please fire away. All right, so I've got a question about being able to make a big culture change and my experience and if I could talk more about it. I would have a hard time saying so far in my career that I've been able to make a big culture change. So I graduated from PT school five years ago and mostly in my work experience so far I feel like I've learned about culture change more than been able to affect change myself, but the more I learn and see things happening the more exciting I think it is. I think there's so much we can do. I think clinical people will be the ones to do it. I don't think this stuff comes from managers. I think it comes from clinical people and I think our system as I mentioned I think once briefly it doesn't exist to dictate us. It exists to facilitate and enable us and somehow it has evolved into this thing that actually is just the opposite. The system in my opinion is the barrier and to say that as a clinical person I think is not a small statement. I mean I'm saying we need to totally change the system of how healthcare works. But to do that in a meaningful way you have to outline your problems and understand them to a high degree and that make change that can be measured and show how it actually makes a difference. The big thing is the mismatched incentives, things that are best for patients are not always the same as what's best for a hospital and almost definitely different than what's best for a system without out of control costs, and I think as PTs we see this more closely than anybody where our work produces relatively low revenue. If you're an outpatient setting, maybe you have your own practice. The best thing if your interests were in line with everybody. I mean you wanna get your patients better as fast as you can and in as few visits as possible,

but if you're working somebody else's clinic maybe they're pushing you to get 90% productivity and bring everyone back for eight visits and it's just a system that leads to problems like this and so these are all in a way problems of our own making which I think we can be frustrated by or we can say that means they're problems that we'll be able to solve too. So I think clinical people are the ones to do this and I hope that everyone feels empowered themselves and in their organizations to do that. And I think if you're interested in learning more, certainly there's a lotta great literature about there. I'm gonna skip ahead to my last references slide here. These books I think are all really fantastic and will give you a lot of information about just organizational change and specifically I think in healthcare these ideas are so timely.

- [Calista] All right. Well thank you so much Dr. Corsino. We do have a couple questions or clarifications on two of the quiz questions. I don't know if you have those close to you but they were asking a clarification on question three and four. I can go ahead and read those if you don't have them close to you.

- [John] Sure, please do.

- [Calista] Okay. So question three is, inequality inside or outside of work leads to disengagement. Which is not a potential source of perceived quality in healthcare today? A, compensation. B, racial discrimination. C, inadequate perception of professional scope, or D, productivity requirements?

- [John] So my view about that, definitely some of the potential sources of inequity are straight forward but everyone's got the same productivity requirements right? So they're, we're not gonna feel like that's unfair between each other. So I don't see productivity requirements as being a source of inequity and that's certainly not something that's born out in the literature either. So my view of that is productivity. Something across the board.

- [Calista] All right. And then number four is productivity has been blamed for limiting both face to face time with patients and perceptions of self efficacy. Which of the following is a sustainable strategy for limiting the dissatisfaction resulting from productivity and requirements? A, schedule changes to accommodate longer breaks between patient encounters? B, utilization of creative approaches for demonstrating value and settings where productivity is not the most important metric? C, most frequent, I'm sorry. More frequent patient visits and D, manager reassurance?

- [John] Sure. So, yeah definitely changing frequency of visits and reassuring your workers is not gonna effect their perceived impact of what they're doing. To me that's utilizing creative approaches to demonstrate value where productivity is a metric that's used but isn't necessarily the most important one. So for me that using things other than productivity to demonstrate the value of the work that you're doing is the answer to that.

- [Calista] All right, well that was our last question. We just have some other positive comments in the Q&A coming in but thank you so much for presenting for us today Dr. Corsino, and such an interesting topic today and thank you everyone for attending all week long and if you miss any of those courses, please check those out. Again, thanks again John.

- [John] Thanks so much for having me and thanks everyone for listening. I hope you can go forth and find really meaningful work that I'm sure you're already doing. Take care.