NCTRC Webinar - Burnout & Tele...ves while Connecting to Others

Thu, Nov 20, 2025 10:30AM • 1:14:13

Aria Javidan
Hello. My name is Aria Javidan, and I'm the project manager for the National Consortium of telehealth resource centers. Welcome to today's webinar, burnout and Telemental health, reconnecting to ourselves while connecting to others. Today's webinar is hosted by the Northwest telehealth Resource Center. These webinars are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs. Before we get started, we did want to acknowledge National Rural Health Day today. National Rural Health Day showcases the efforts of rural healthcare providers, state offices of rural health and other rural stakeholders to address the unique healthcare challenges that rural citizens face today and into the future. More information is available at power of rural.org to write a little bit of background the consortium located throughout the country. There are 12 regional telehealth resource centers and two national one focused on telehealth policy and the other on telehealth technology assessment. Each serve as focal points for advancing the effective use of telehealth and supporting access to telehealth services in rural and underserved communities. We also want to highlight a new update from the Center for connected health policy through funding from the National Association of Community Health Centers, cchp has relaunched the federally qualified health center Medicaid section for each state on its website, you can now see how each state approaches telehealth for FQHCs in their Medicaid program, and more information is available through the link there on the slide. We did also want to share that we have a survey, and we are collecting tele success stories from both patients and providers who have benefit, benefited from telehealth with support from a telehealth Resource Center. So share how your telehealth Resource Center helped make telehealth work for you, for a chance to be featured, along with your organization our monthly consortium newsletter, and that link is available there also the QR code, which we'll send you to the survey. A few housekeeping notes before we get started. Your audio has been muted for today's webinar. Please use the Q and A function of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please only use chat for communicating issues with technology or communication access issues. Please refrain using the chat feature to ask questions or make comments. Please note that closed captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded, and you will be able to access today's and past webinars on the nctrc YouTube channel and the nctrc website at telehealth resource center.org Please. And with that, I will pass it over to Nikki Paris show, director of the Northwest Regional telehealth Resource Center.

Nicki Perisho
Thank you, Aria, and hello everybody. It's such an honor to share this, this presentation with you on Rural Health Day, providing access and services to rural citizens is so important. And and as ARIA said, I'm Nikki parisha. I'm the director at the NRT Aria, the Northwest

David Kopacz
Nikki and everybody. I appreciate the opportunity to be here to speak today my emails on this first slide. So if you ever want to reach out to me, feel free to do that next slide, please. So anyone who's worked in telehealth or Telemental health knows there's benefits and there's costs to doing Telemental health flexibility. This is a double edged sword. Actually. Today I'm in my house, but I've got workers in the house. We just moved into Nelson, Madison, Wisconsin, and you're working upstairs in my office putting in bookshelves. So I'm in another office. I'm hoping that the Wi Fi holds them. And yesterday, I

had two different sets of contractors, and so I was trying to work when there were saws buzzing in different parts of the house and outside. So the flexibility can be a double edged sword, as well as benefit, you got decreased commute time for both patient and clinician, increased accessibility for those who have access to Wi Fi and the technology, and if they can work the technology, you can personalize your workspace. You can take exercise breaks, nature breaks. You can tap breaks with family and pets. I always have like Corbin with me, who's sitting behind me here, and we took a nice walk over the lunch hour. So but there's also costs. There's isolation all day long, other than the instruction workers who are here, you know, I'm not seeing another physical human being also, too. Even though I'm talking with patients, I often don't talk with the rest of my team that I work with nationally, there's emotional disconnection, which is one of the kind of riots, of burnout, disconnecting from things, or emotional exhaustion. You've got technology as a mediator, which is a double edged sword, too. You know, there's ways that it's great and there's ways that it can have drawbacks, particularly if it's not functioning well, which I had on Monday this week, with a lot of tech issues. There's cognitive overload. We'll talk a little bit about this concept, or Zoom fatigue, as they talk about during the pandemic, where you just feel like you've spent too much time staring at a screen and and you just feel kind of overloaded by it, what I called homing from work during the pandemic. At some point I realized, you know, our team went totally virtual, and I realized that I was doing more work from home, and really felt like I was homing from work rather than working from home. So having those boundaries and, you know, knowing when you're working and when you're not working can be harder in a home. Telemental health setting, techno technical challenges like increased frustration that can interfere with with clinical time. This week, on Monday, I just had all sorts of problems going on my computer. Wasn't recognizing my camera. I had to use my laptop. I had to sign in like, four times to try and cook with one patient. So there's all these kind of background stresses that you don't have when you're just walking down the hall and getting your next patient. And there's increased sitting in an activity, and you sit more still when you're talking to a screen. You sit still because you see yourself the feedback, visual feedback, compared to if you're sitting with a person face to face, you move, you cross your legs. You do different things. You can kind of slide over to the side. You can lean like this. But when you see yourself on screen, we tend to kind of sit more static. So that can be a physical challenge. Next slide, please. Yeah. So Maslow's hierarchy, it gave it away. This was supposed to be an automation, so, but the Maslow's hierarchy has been updated, and they added Wi Fi as the kind of core base of Maslow's song hierarchy, even before food, water, shelter and warmth. So this is kind of a joke from Kaufman. I believe you go to the next slide. I think his name might pop up at the bottom there. Yeah, this from something who worked on some unbleshed manuscripts of Maslow's Next slide, please. So what's human connection versus technological connection? I think about this a lot. You know, what's a whole human being? What does it mean to develop ourselves, not just as technicians and clinicians, but as whole people, so that we can meet the whole person of the patient? So human connection, you've got the body to body, which could include nonverbal, emotional connections, mental connections, heart to heart connections, and even some might say, a Spirit to spirit connection. From a technological perspective, though, you've got three things mediated through technology. Technology, you've got your wired connection, your audio, your video, your chat, all these different functions, you might also have multiple things going on, not just with your patient, but with your team, and these can intrude and ping onto your screen. And technological connection prioritizes the mental we can see and hear, rather than sometimes what we feel or noticing nonverbal or kind of these more subtle heart or spirit levels. Next slide, please. So are burnout rates higher for Telemental health, this is something people have looked at kind of mixed. You know, some people say yes, or maybe some people say no. I think we also have to look at a lot of variables, because I've done telehealth, where I've been pinging back and forth with my team all day, and feel like I'm communicating with the nurses on my team in this job. You know, it's really kind of a solo it's almost like a group, like, kind of a group practice type of thing. There's people helping me, but I've never met them before in person, and most of my interactions are just through takes, rather than me having had a face to face relationship with them. So we have to look at what these studies. Was it done during the pandemic, when there were a lot of other stressors, and also not

just telehealth, but the whole kind of ecosystem, or ecology around the job experience that people are having. Next slide, please. So what is burnout? I mentioned the triad, the burnout triad that maslock has talked about, feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, which could be detachment. And I mentioned that telehealth, kind of, just by its nature, has a degree of detachment because we're we're contacting, communicating with people that mediate it through Technolology, rather than face to face, and then a reduced sense of professional efficacy. That kind of feeling, no matter what you do, you're always behind. You're never doing a good job. So this is kind of how we think about burnout. Next slide, please. So the pandemic crash course in telehealth, 4,347% increase in telehealth measured in March of 2020, so we really went from telehealth being, you know, something that was kind of specialized. So I always felt like I had to get a whole bunch of training in it. I was doing a little bit of it in a rural talking about rural health day. I was doing a rural native veteran program for half day a week. And so I was able to reach out to people living, you know, distant places in Washington. And but it was, you know, it was still a little wonky, you know, it wasn't the status quo telehealth before the pandemic. So then, bang, the pandemic happens, and everybody's doing telehealth. Next slide, please. So then the pandemic ended, I think, like officially may 2023, I think, is when the pandemic if somebody else knows, I've got it in my notes, but I can't see my notes on the on this slide view here. So the pandemic ended, but our is the stress of the pandemic over. For me, I know I have a slightly skewed view. My father in law died of the COVID during the pandemic. My dad, mom and dad, COVID at birthday party, we were planning everybody to come and meet, but that they get COVID right before the birthday party. My dad, after COVID, had cognitive problems that didn't bounce back all the way. I developed cancer. I was diagnosed with cancer, with melanoma, and went through treatment cancer treatment during the pandemic, and had complications from that of cancer free for three years, which is great. I've got what seemed like maybe permanent nerve and muscle effects from the treatments. So I know when I think about the pandemic, it still feels like it's kind of going on. My wife and I just moved across the country, and a cat died the day before we were going to drive across the country, and it just feels kind of like all these things are still happening, at least in our lives, looking kind of more objectively. The American Psychological Association puts out a stress in America report, and so in 2023 they were warning about the possibility of collective trauma. And as all of us know, treat trauma, the effects of trauma don't end right when the trauma ends. They can linger for a period of time, and there can be ripple effects. A lot of times we think about trauma is an individual Sorry, I lost my train of thought for a second. Trauma is an individual occurrence. Trauma can be a collective issue as well. Groups can be traumatized. Organizations can be traumatized. And cultures or countries or even the world, with the pandemic, there can be a degree of global trauma, collective problem. So the APA said, superficial characterization of day to day, life being more normal is obscuring the posttraumatic effects that altered our mental and physical health. There's mounting evidence that our society is experiencing the psychological impacts of a collective trauma so and when? When can we say that collective trauma is over? And I suppose part of that depends on how we address trauma, we could even say that the political polarization and the polarization that's happening in our country and across the world, maybe some of that polarization is the way that trauma is getting played out, this collective trauma. So next slide, please. So this is from the Institute for collective trauma and growth, and they kind of plot out this graph. This isn't necessarily based on research points or study points more and overall gestalt of their experience of working with organizations or cultures as they go through trauma, the Sudden Impact phase, the heroic phase, where everyone kind of bands together and says, We can beat this. You know, we've got in line workers and people are celebrating our medical teams that are working and banging pots and things. But then there becomes the Disillusionment phase, where it keeps going on, and you're like, This is starting to get old, and kind of a bottoming out, but then it doesn't just bounce back to where you were. You know, kind of goes up and down for a period of time and and this organization says it can take two years to five years of community process, and that's assuming you're actively working on it. If you're not actively working on it. We know people don't always get better from trauma, maybe organizations or culture societies as well. But there's these ups and downs and

rebuilding and restoration phase. One of the things that I'm really interested in with burnout is an idea called post burnout growth that we've been developing with a friend of mine, Lucy Houghton, and in that we think about what can we sort of grow through the burnout, not just sort of bounce back? The idea of resilience, a little ambivalent about it. Resilience can mean if you're strong enough and resilient enough, you should never be burnt out or never suffer. That's just not true. Suffering is part of the human experience. It also kind of maintains an idea that you're going to go back to who you were before and again, those of us who work with trauma know that you can't make the trauma unhappen. It doesn't like not become part of the person's life and narrative. The way people grow from trauma is by incorporating it into their lives and making sense of it and meaning from it, and believe in developing a sense of greater purpose in their life. That's the idea of posttraumatic growth. So this organization, Institute for collective trauma and growth, talk about the idea of a wiser living phase, where after a collective trauma, if it's managed in a in a good way, in an active way, you can actually have a higher level of functioning after the trauma and Hea level of community coherence than prior to the trauma. If it's not managed well, then you have the fragmentation that we kind of see now Next slide, please. Okay, so let's shift gears a little bit. One of the things that Technolology allows us to do, is to do things faster, more efficiently, and so we're constantly adopting new technologies because they're supposed to make our lives better. Cal Newport talks a lot in the more the tech world than the self world or healthcare world. He's written a book called Slow productivity, lost art of accomplishment without burnout. And Hea actually says that Technolology is fueling burnout because we're we've got this expectation that we're doing things. We're supposed to do things so quickly and so efficiently, and the computers can do that, but the people can't. Human beings run. Don't run on computer time. Human beings need to reboot for, you know, eight hours a night or so to sleep. They need to reboot for a period of time with family and friends and socializing and relaxing and all these different things, a computer can just keep on working. So instead of always trying to increase productivity and efficiency, Newport argues the opposite, and says that if we want to really void burnout, and if we really want to make good products, we need to do fewer things. We need to work at a natural pace, and we need to Obsess over quality rather than quantity. And so much of of what we do is measured by how many patients we see, how many dollars we bring in, all these quantitative measures, rather than how good of a work are you? How good of work are you doing with somebody? What's the quality of your work? And so Newport also talks about this idea of Pseudoproductivity, of using visible activity as the primary means of approximating actual productive effort. Next slide, please. So why do we need a different kind of productivity? Newport says that this relentless overload that's wearing us down is generated by a belief that good work requires increasing busyness, faster responses to emails and chats, more meetings, more tasks, more hours. Next slide, please. So here's some practical applications that Newport recommends simplify your work day, try to focus on one task at a time. And he goes over research about how that's how the human brain works. When you switch tasks, you actually the period of time that your brain actually isn't functioning on the new task. So it's kind of a limbo, time or downtime, double your project timelines, however long you think it's going to take double that forgive yourself for not making deadlines, limit missions, projects, daily goals, pay attention to your surroundings and create rituals. Now, some of these things won't transfer over into a clinical environment. He may not be able to say, I'm going to see the number of patients. I'm going to see in one day. I'm going to do it in two days. Depending on if you're self employed, you could do that, but if you're working for an organization, they're not going to be too happy if you say I'm going to see half as many patients as you're telling me I should. I'm going to do it in two days. But some of these things you can bring in, like trying not to multitask, putting off times a day where you're going to do email or even with teams messages, if you're on a team that's not kind of a triage type team, you let some of those things wait till later, turn them off and make sure they're not intruding into your clinical work time and paying attention to your surroundings. That's one of the things that's great with telehealth, is you can create a supportive, healing environment to work from. And you can create rituals around your work with the dog. One of my rituals is, I'm always taking walks, and that's nice working with the dog, because even if I think I'm gonna, you know, blow through lunch and try and catch up on things, I look at him, and he

looks at me, and I'm like, you know, you have to go out. I can't push through this next slide please. This is an interesting kind of related concept from McKeown from Harvard Business Review, saying that if you want a top performing team, ask for 85% effort. So instead of constantly like redlining and trying to do 100% he says that the idea of maximum effort equals maximum results is an outdated way to think about peak performance, and the research doesn't actually show that that works. And so he recommends this 85% rule, that to reach maximum output, you need to refrain from giving maximum effort, you could imagine a graph of this too. Of like, you know how much effort you're putting into something and how good of a job you're doing. And we all know when we become stressed and we're doing too many things and we're thinking about too many things at the same time, we don't do as good of a job, we don't feel good. We're more likely to burn out and get cognitive overload, and plus, we miss things. You know. I'm sure all of us have had times where something happens and you're on screen with the patient. Actually, this just happened to me yesterday, Corbin, my dog, got sick, and he, you know, had an accident right while I'm in the middle of a session, and there's people, you know, with saws outside. And I had to try and figure out what's going on. What am I going to do in this situation? I need to, I need to take a break from this and figure out how to juggle these multiple things at the same time. So I like this idea. Again, this is something as a kind of a worker bee. You can't really tell your boss, I'm just going to do 85% but anyone in leadership, this is a good idea to think about. How can we buffer some time for our teams so that we're not always trying to book them and schedule them all the way up to 100% How can we give a little bit of flex time? Because there's always going to be things that come that come up. That extra 15% no one is going to be sitting around not doing anything. You know, there's always going to be things that that come up. So next slide please. All right, so this is an embedded video. Let's go ahead and play the video. The instructions will be on it to watch here.

Aria Javidan
Okay, just give me one sec. I'm going to optimize the audio for

David Kopacz
zoom. Oh, thank you. So this video comes from some of the work of Shibli. I can't remember the other guys name. They were university Illinois in campaign. Okay, great. Here we go.

Speaker 1
This is a test of selective attention. Count, how many times the players wearing white passed the basketball. How many passes did you count? The correct answer is 15 passes. But did you see the gorilla. This video is from research by Daniel Simon's and Christopher Chabris, and is copyrighted. It is available for use in talks, training and teaching on DVDs from Viscog Productions.

David Kopacz
Go ahead and pause it or go to the next slide here. Oh yeah, next slide. Okay, so they've written this up in the Invisible Gorilla this study. I don't know how many of you people, if this is the first time you've seen it or heard about it, didn't see the gorilla, but when they've done studies, about 50% of people don't see the gorilla. And the profound thing about this, for healthcare is, if we're counting things, you know, we're doing scales, standardized scales, and Gad sevens and PHQ nines and PCL fives, and we're counting and tallying up these things. We're turning everything into a quantitative value for the patient to encounter. We may not see something really important. This study was done again with radiologists, where they put a gorilla on like a chest X ray, and it was 48 times the size of a typical lung nodule, so it wasn't a tiny little thing. 83% of radiologists didn't see this gorilla because they weren't looking for it. That's kind of how our brains work. Our brains look for, they see what they're looking for, and they don't see what they're not looking for. That's why there's all these, you know, advertisements and and initiatives of like start seeing bicycles, start seeing motorcycles, because our brains are looking for something. They're looking for a car, and they may not see something else. So the implications for

healthcare are tremendous for this that if we don't create something that's kind of a human centered design for the way we're interacting with Technolology, we may miss important clinical things, and we might even not see the patient. We might not see something really important, obvious, like a gorilla. Next slide, please. So the Myth of Multitasking, you know this. This has been studied by attempting to do two things at once. People make approximating twice as many errors and take twice as much time overall. And individuals who call themselves high multi taskers have a slower reaction time and are worse at filtering out irrelevant information. So this is another thing. People will say, I'm a good multi taskers. But really, the human brain is not designed to multi task at best, it can do things sequentially or switch back and forth, switch from one set to another set. Next slide, please. So cognitive overload, let's talk a little bit about this. So Videoconferencing, there's been a lot of research over decades, not just telehealth, but videoconferencingconferencing, and it's found there's a higher cognitive load versus other forms of remote work, like telephone. Like for me, when I was working at the VA remotely, I'd love to have in a telephone session periodically, because I could stand up, I could walk around the room, I could shift in my chair. I didn't have to make sure I was, you know, on camera centered. And it was just a little felt a little bit more relaxed. And although I was missing non verbal things, I felt like I was able to listen to the person better than if I was looking at the video and having things popping up and teams messages and all that trying to filter that out. Also with Videoconferencing, you have these tech difficulties where you have drops in video feed or sound delays. You have the distractions on the computer, as I mentioned, the self monitoring, as I've mentioned a couple times, also to where your eyes are looking. Depending on how you set it up, you might be looking like I have patients I see, and they're like, looking like this. The whole time they've got two screens, and they're like, like this. You know, it is difficult. It's challenging to try and get it set up so that looks like you're looking at the person and the camera rather than looking at the eyes on your screen. Overcompensation, they find that people do increased emoting, and they talk 15% louder, so that might take 15% more energy that you're you're trying to project, because you're in an unnatural setting that's mediated by Technolology. People are continuously having to learn new systems. Just when you figure out how to work a system, there's an update. And then part of your energy and attention is on, how do I get this thing to do? Where do I get this video screen to go? You know, it used to be right here, and now it's it's moving over. Now I've lost it, and you're trying to get it back. So you know all these different things that happen when you're on a new system, and the lack lack of direct eye contact. So with direct eye contact, there's studies that show there's increased oxytocin, and that helps with social bonding. So there's a theory that perhaps when we're working on video, we don't really have that direct sense of eye contact, and so we may not have these types of neuro hormones or neuro chemicals that help with person to person connection and bonding. There's the misunderstandings and disconnection and shift and reward fatigue, Brain Balance. Not sure what that means at this point, reward fatigue, Brain Balance. I'll think about that. Maybe that'll come back to me. Let's see the next slide, please. It may be that getting back to the oxytocin interpersonal contact is inherently rewarding, whereas being on a computer screen is not inherently rewarding. So you're trying to work through the technology to get that reward of interpersonal connection. So I think it's interesting to look at cognitive overload that's been studied and Videoconferencing and to wonder, is this brief burnout? Burnout, again, is that feeling of energy depletion or exhaustion? I'm sure any of us have worked in telehealth have felt that time where you're just like, my brain is full, you know, I just can't get my brain to, like, do the next thing I've had so much, so many different complications and tech issues. Today I've used up all my brain energy on just trying to get the appointment started. You can have that distancing from the other person, and it's easier in a telehealth setting to not have the empathy or connection for people, because it can almost seem like it's not real in a way, like you're talking to somebody and, you know, click, something goes wrong, and you lose the person. You're like, well, I've lost the person. You know, what can I do? They're gone, rather than when you're face to face, you know, people, they don't just disappear like that. And this reduced sense of professional efficacy. I've had that this week of having so many contractors and so many distractions and so many tech issues where I'm just like, I just am not good at my job. I just feel like I'm a loser or something. I don't know if other people get that, but, you know, there's days where it's just

like, oh my god, I just cannot handle this. You know, that's kind of a burnout, but it's brief burnout, because you sleep and the next day you feel like, Okay, I'm ready to go. Whereas burnout usually lasts longer, lasts longer than just one day. Next slide, please. Okay, another shift here. Slow medicine by Victoria sweet, a great book. She also wrote God's Hotel, which is another great book. And so she writes about slow medicine, the idea kind of like Cal Newport's slow productivity. And she says the key strategy is to do the most important things first and let the others go next. Slide. So here's what she calls fast medicine. She compares fast medicine and slow medicine, and she developed the idea one day when she was when her father had, I believe it was a stroke, and she was in as a visitor, and just viewing how the medical system worked from the outside, as her father was getting care, or what she thought not such great care. So she said, fast medicine is everything looks so good in the computer, and yet what father had gotten was not medicine, but healthcare, medicine without a soul. And what do I mean by soul? I mean what father did not get? Presence, attention, judgment, kindness, above all responsibility, healthcare deconstructs a story in 2000 tiny pieces, pages, boxes and check marks for which no one's responsible. So how can we bring in slow medicine in an environment that's mediated by Technolology, and that's a challenge. Next slide, this is something I've developed and Greg serpent, I put an article on clinician resilience in Dave Raiko and Benny mini cello 's integrative medicine textbook, fifth edition of the textbook, and we talked about the cost of caring. I found sometimes when I talked to professionals about burnout, they'd say, Well, that's not burnout, that's compassion fatigue, or that's not compassion fatigue, that's Vicarious traumatization. And I got kind of frustrated by this way of people taking clinician suffering and trying to compartmentalize it out or saying it's not really burnout, it's depression. We should treat the person for depression, and then if they don't respond to that, then maybe it's burnout. So I developed word the cost of caring, or a phrase that kind of includes all these different types of suffering that we can have. Working in health care, we've got burnout and compassion fatigue, that feeling that we just don't have any anything more to give. We can be in traumatic situations, or Hea of trauma, where we get secondary or Vicarious traumatization. We can actually be traumatized working in the ER, even working telehealth, you have a patient who you know, something bad happens to or they die by suicide, and you can feel, Oh, my God. What you know? What happened to me? This is what happened to this person. What happened to me? Did I do something wrong? This kind of traumatic experience that can happen when you're working with people who are having difficult times in their lives. We can have Demoralization, which isn't quite it's sort of a different concept than some of these others, in that it's just losing a sense of meaning and purpose in your work. And the counter to this would be re moralization, how you rebuild a sense of kind of moral engagement in your work. And there's a number of people have looked at the idea of moral injury, Z dog, MD, has a good five, six minute video about it's not burnout, it's moral injury. And talking about it's not a problem with the individual clinician. It's a problem with the system. The systems are setting us up for failure because the systems aren't human centered in their design and moral distress is kind of a spectrum towards moral injury. I work with the term soul loss. I've worked with a fair number of Native American patients and veterans, and spent some time working with Joseph Ray, LW, who's also goes by the name beautiful Painted arrow. And he grew up a Southern Ute reservation at Vicarious pueblo. And kind of, from more of an indigenous perspective, we'll talk about soul loss as a form of illness, and Soul Retrieval as a way of, kind of becoming more whole again. And then, you know, just to remind us that this isn't just a clinician complaining about being busy or complaining about their job, all of these things can lead to suicide. We know that many healthcare workers have higher suicide rates than the general population. So this working with suffering, somehow that suffering can get into us and it can drag us down as well. And so that's part of the cost of caring. And then the idea is, how do we work wisely with the suffering that's an inherent part of life, and that our jobs are to move towards people suffering rather than away from it. Next slide, please. I Thomas, more psychologist, wrote a book called the care of the soul, and he talked about the idea of soul loss, and many of these overlap with burnout and Demoralization, feelings of emptiness, meaninglessness, vague depression, Disillusionment, loss of values, a yearning for personal fulfillment and a hunger for spirituality. And I'll just mention an interesting thing is, one of the things that we offer people for burnout are like meditation, Tai Chi, Yoga.

These are things that come from spiritual traditions, and we're starting to bring that back into medicine to say we need something that cares for the soul, so to speak, of the of the clinician, we need time to sit and reconnect to ourselves. We need time to move our bodies and be present and embodied in Tai Chi or yoga. And so by incorporating some of these spiritual practices, even though they're secularized, it may be a way of kind of this hunger for spirituality to come back into medicine and healthcare. Next slide please. So you know, I thought about this burnout is soul loss. So what's the soul? You know, we think about, well, what's a whole human being? What's human connection? What's the soul? It's kind of amorphous. So maybe we can think of the soul as a source of you can kind of click through the slide here, the animations. Vital. Vitality, creativity, connection, passion, compassion, renewal. So what would your life? What would help you reconnect to your soul and bring it back into your work and life? How can you find a sense of vitality, a sense of creativity, a sense of connection, connecting to yourself and connecting to others, feeling a passion for your work, filling up your compassion so you don't feel compassion fatigue or empty, where you don't have anything more to give, but you feel overflowing with compassion, where just naturally comes as an expression of who you are. And how can you bring the sense of renewal? Next slide please. So this fits back to this idea, of course, post burnout growth. How can you use your burnout as a way of growing professionally and personally as a human being? And I think it might be this is another thing I don't like with resilience, where you kind of have this idea, if you're resilient, you'll never get burnt out. And I think probably you have at least four episodes of burnout. Most people in their career probably have some degree of burnout when you're studying it as a student, some degree of burnout when you're a new practitioner and you're trying to, you know, make come to terms with the field, you know, mid career burnout, where you're good at your job, and then you wonder, you know, but my job is taking so much from me. I'm good at what I do, but what about the rest of my life? That's sometimes like a midlife crisis, and then also maybe a burnout period of time, or a self reflective period of time when you're nearing the end of your career and you're wondering, you know, what, what have I done with my life? What? Who have I helped? What has my sacrifice of time and energy made a difference in the world? And so with post burnout growth, we're looking at it's kind of a positive psychology perspective that for each cost of suffering, there can be a thriving counterpart, moving from burnout to post burnout growth, trauma to Posttraumatic growth, dehumanization to dehumanization, Demoralization to remorilization, soul loss to Soul recovery and from suicide or thoughts of meaninglessness or purposeness, to finding meaning and purpose in one's daily life. So Lucinda and I have written a little bit about this, and CLOSLER, Johns Hopkins blog, and it's something I'm still working on. This idea, in some ways, I'm still kind of groping in the dark with it and other ways it fits in with a lot of positive psychology and a lot of ideas around transformation. So next slide, please. And transformation means you're using the suffering to grow, rather than avoiding the suffering or getting rid of the suffering. So this is a model I've been using for a while, from my first book re Humanizing medicine and my latest book, caring for self and others, about what makes a whole human being. And so when I'm working with clients, I'll think about and when I've worked with myself, when I was going through cancer treatment, I thought about this model as well and applied it to myself. What am I doing my body? What am I doing for my emotions? How am I caring for my emotions? How am I caring for my mind and my heart, my creative expression, my intuition, this, this kind of capacity for direct knowing that's not necessarily based on analytical thought that plans things out step by step by step, but just that gut sort of sense of knowing of what you want to do or what's right for you, this level of spirit and soul. And when I talk with veterans, I would say this isn't necessarily religion. It might be religion for some people, but it's really about what helps you feel alive and vital and connected. It could be playing with a pet or playing with kids or grandkids. Could be walking in nature. It could be, you know, painting a picture. Or it could be more spiritual practices, meditation, yoga or religious ceremonies, so and then I also look at your relationships. This is an important part of what makes a whole human being. We exist in connection with other people and our physical environment and our phase of life as well. So all these things go into a whole human being. And if we want to be a whole human being, then we need to attend to each of these different domains. Next slide please. So here's a worksheet that I use, taking each of these different dimensions and looking at what person's already

doing to care for these different dimensions and what they would like to do to care for them. Sometimes people feel like they're not doing much of anything for themselves, or that they don't have any idea what they'd like to do for say, their creativity. And so I'll say, Well, what did you do as a kid? Was there you always wanted to do you never did? Was there something you like to do in the past that you've given up? Can you somehow loop back to that and bring that back into your life on a regular basis, and use this worksheet on like a weekly basis or a monthly basis. And then decide which of these directions using a coaching model rather than a therapy or directive model, asking the person which of these dimensions would you like to work on. How can I support you in moving towards your goals? And so this is not a it's kind of a tool for exploration. More than quantifying, like getting a number to rank somebody of how they are, it's comparing the person against them, the ideal self and their current self. And way get just a couple more slides here next slide. So this is where I've developed some of these ideas, the idea of how medicine, I felt like I was losing parts of myself when I was going through the medical training. And I developed an idea of a counter curriculum of re humanization. I felt like I was losing, you know, touch with my innocence or my soul, and how could I rebuild myself so I'd carry around a book of poetry or a novel and make sure the last thing I read every day wasn't biochemistry, it was something else, something more in the humanities, and you're making artwork, meditating, physical exercise, all these different things that weren't a priority in learning medicine, I thought about, how can I re humanize myself by adding them back in, and this caring for self and others, this is really where I've looked more at the idea of, how can we transform burnout? How can we develop an idea of post burnout growth? Next slide, please. I place. So those are kind of perspectives I've been developing over the last, you know, say, 15 years. I also worked in VA full health. This is open access, so you can just download these things for free, even if you're not a veteran, or your clients not a veteran, or you don't work at the VA, these are open access. This is a similar type of thing as that worksheet that I've developed, the personal health inventory, where a person ranks where they are in their physical, mental well being, and then how their life is day to day, reminding themselves what matters most or what's most important to them. And next slide please. And then going through, it's a little hard for me to read. I don't know if you all can can read it, but going through the different circles or sub circles of the circle of health, and a similar thing, of where are you now? Where do you want to be? This does have a numerical ranking, so ranking yourself numerically, and then having conversation live. Did you say you're at a one for spirit and soul, and you want to be in a three? What would a three look like compared to a one? And then some reflections about how you might want to start on this. So it's a nice coaching tool, and I like the visual of the circle of health here too. And I've kind of adapted. I put me, and we in the center there. The website just has me. But I like to, you know, really reinforce that we're all interconnected, and that me, me, when it looks into the the water of a lake or something, we is what's reflected back. Is kind of how I explain it to people. So next slide, I think that might be the last slide. Yeah, yeah. So open for questions, then comments.

Nicki Perisho
I don't see any questions in the Q and A box Aria. Is it possible to unmute for people to raise their hand and ask a question if they have any? No, we,

Aria Javidan
unfortunately, cannot we. We do ask that if you have any questions, submit in the Q and A function at the bottom of your screen.

Nicki Perisho
Okay, great. So Dr KOPACZ, thank you so much. It's such a It's always such a timely reminder for those of us working in telehealth and who are on zoom all day, and I actually really loved your comment about in the very beginning, about how when you're face to face, you're moving all the time. You're sometimes doing this. And after being strictly on Zoom for five years, I find myself doing this in

meetings all the time now, and just repositioning, which I didn't used to do that. So that was really kind of a point I resonated with early on. But I see we do have a couple of questions here in the chat, so I'll go ahead and start one. The first one is, how do you get buy in from employers for the 85% expectation.

David Kopacz
Yeah, that's a hard one. I mean, you could say the research, you could show the research, can say, this is Harvard Business Review, you know, this isn't Yoga Journal or something. It's, you know, kind of hard nosed business perspective for how we can make things, you know, more human centered. So I suppose one thing could be starting a conversation around what is the impact of the institutional environment on the people in the environment. And you can also appeal to like Mayo Clinic. Shawna felt has done a lot of research. And the Mayo Clinic, there's a book that came out of like, I think it's something like the 12 different things to prevent burnout and healthcare. And what they recommend, after studying burnout at the Mayo Clinic is, when you start trying to work with burnout, don't offer self care strategies. Don't offer a meditation class. Don't offer yoga, because that sends the message that there's a problem with you. Start with Inattentional variables, things that are burning people out. So you can appeal to experts like that, who at the Mayo Clinic are saying, you know, we can't just tell people to go home and meditate on their own. That's not going to solve for now.

Nicki Perisho
Great. Thank you for that. The next

David Kopacz
couple I got an idea. The idea this happened during the pandemic. Meetings aren't 60 Minutes. Meetings are, you know, 50 minutes or something, or let's shift it to a 30 minute meeting, and you have 30 minutes for yourself.

Nicki Perisho
I love that we are starting to incorporate that in our own world, because the back to back 60 minute meetings is just so really, that's a great suggestion. The next comment is a comment, thank you for this wonderful presentation. And then another comment, this presentation was very informative. I appreciate all the resources that were discussed I will share with other providers in my practice. Thank you so much. And then we have a comment here. David, I'm the technical writer for a Sud service. Our program started as telehealth long before it was mandated. One strategy we use to help our staff and clients cope with trauma and trauma triggers is we partner with a local rage room. This operates from a trauma informed perspective. Our clients have all they got from Hea or more healing out of a rage session than hours of therapy.

David Kopacz
Good, good thing. And also, too, they're going someplace in person. You know, they're going some place physically and doing something physically, and not just talking about things at the mental level.

Nicki Perisho
The next one is how to manage the stress and burnout of the political climate and trying to keep holding hope for our clients and ourselves in such uncertain times.

David Kopacz
Oh, man, that is a great question. I wish I had a good answer. One one year, my New Year's resolution was to read a book a month on hope. So that was, you know, kind of how I worked with it. I've got a friend, Chris Smith, I do a podcast with, and we try to do about once a month. He's got a book called

Hope opens doors. And so we've talked about on our podcast, you know, how do we maintain hope? I've started to look at it. It's a practice. So hope isn't something that you do once and you've got and you're done with it. So just like yoga or meditation, it's a practice of returning to it, of building up, you know, taking a break, building up a sense of perspective and healthcare. This is an interesting thing that I talk about a lot. There's a great book by compassionomics, by tresiak and mazarelli. Compassionomics is the name kind of like genomics, but compassion and they studied compassion and healthcare, and concluded compassion is an evidence based treatment in healthcare. And one of the things that they talk about the underlying you kind of neuroscience of compassion, they can contrast compassion empathy, that empathy is feeling for somebody else but not being able to act on it so it actually lights up the pain circuit in the brain, compassion, they defined as feeling for someone, feeling what they're feeling, but acting to help them. That lights up the reward circuit in the brain. So I think about this a lot, even when I'm with the patient, one on one, and I think what is one practical thing that I feel like I can do that is an action for this person, and what is something that I can think of that's a practical action for them to do, to try and shift from this pain circuit into the reward circuit. So, yeah, I find that I kind of return back to that too. Hope would be, how can you trigger the compassion circuit versus the empathy circuit, where you end up feeling more pain rather than feeling a sense of reward. And probably people have had this experience clinically, where you're in a really, really tough session with somebody, and you come out and you're sweating through it, and then you're like, Oh man, I feel like I really helped someone, even though that was really, really hard, and you have this sense of reward and gratitude for the person to share that with you, and and the sense of like, oh my God, I don't know where some of that stuff came from. I was able to really pull these things together, and it really helped. We really clicked and connected. And to try and have more of those types of things where you're connecting to yourself, connecting to nature. Sometimes I'll just look at the trees and think, okay, the trees doesn't matter. What's happening in politics, the trees are growing. They're doing what they're doing. I'm going to go hang out with the tree for a little while.

Nicki Perisho
I love that one, especially being in northwestern Montana, we have a lot of Yeah. Next question, is there any data on increased quality of work or outcomes when project timeline was doubled or extended.

David Kopacz
Newport will talk about this. Hea is a fairly data driven guy, so he looks through some of the different studies and research, as well as talking about sort of case studies of creative people. So Hea kind of moves back and forth between the research, doubling the timeline. I don't know whether that's done too much. You know Newport saying you should do it. I don't know people have looked at doubling the timeline, but it's a good question. Maybe we need more research that's up everybody on some research. We need more research on that.

Nicki Perisho
All right, next question. Physician suicide is a growing concern. Many refer to burnout. Is there any research study specific to rate of suicide in telemedicine versus in person? It's a good one.

David Kopacz
Yeah, I don't know of that there may be. I'm an ambassador for the Lorna Breen Foundation, which is a physician organization for physician suicide, and I can ask them, and I'll send it to you all if I find something on that physician suicide in telehealth setting. Yeah,

Nicki Perisho
that'd be great. I'm actually taking note of that. Yeah,

David Kopacz
yeah. And again, though, I think there's so many variables. We can't just say telehealth. Like when I was doing telehealth at the VA, I had worked really closely with the team. We, you know, one of the nurses and I were talking about our cancer treatments that were going on and every day, you know, we talk about, well, how are you doing? How are you feeling? It felt very supportive compared to my current environment. I don't have a telehealth buddy. I don't have a friend in the whole organization. I have a couple people I've talked to. You know, the most I've talked one on one to even my boss, is probably about two hours and three months, and then it'll be like half hour every six months after this. So it's a very hands off organization. And doing telehealth here, the burnout is going to be a bigger issue than it was when I was working with a team I knew right.

Nicki Perisho
The next question, our team currently has a 75% expectation. The team is still feeling overwhelmed. Where would you recommend we start with the team,

David Kopacz
yeah, yeah. So you're at 75% and still feeling overwhelmed. So I think you know, the first thing would be, can people identify where they're feeling overwhelmed? The Medscape, every year does a physician health and burnout survey. And every year they they, they study. They not so much study, but they ask 10,000 people, that many physicians, what causes burnout, and then they rank the top 10 things, so something like that. What is it that's so making it so difficult? Is it a systems issue? Is it a communication issue? Is it a client population issue, and then to get people's feedback on what that is? So kind of gathering some more information, and also just the act of asking people how they're doing makes people feel better. And it may, you know, just having that type of project might help people feel more support. And then if you can come up with different concrete things that can happen, even if there's one or two concrete things that come out of it, people feel like, okay, I'm being listened to. I'm being heard, and we're trying to make things better, rather than there's nothing I can do. I'm just overwhelmed.

Nicki Perisho
Doctor KOPACZ, thank you so much. We are at time. I think ARIA wants to close us up. I'm seeing from the sign. I just want to share that there are, like 10 to 12 more comments saying thank you, and how important compassion and gratitude is. So again, we thank you for your time, and I'm going to hand it over to Aria.

Aria Javidan
Thank you, Nikki. Thank you so much. Just a reminder that our next webinar is going to be held on Thursday, January 15. We do not hold a webinar in the month of December, due to the holidays. That webinar is still being planned, but it will be hosted by the Center for connected health policy, our national telehealth policy Resource Center, once the webinar topic is finalized, registration information will be posted to the NCTRC events page. And lastly, we do ask that you take a few short minutes to complete the survey that will pop up at the conclusion of this webinar, as your feedback is very valuable to us. Thank you again. To the Northwest Regional telehealth Resource Center for hosting today's webinar and to Doctor KOPACZ for their presentation. Have a great day. Everyone. You.