Caring for the Health Care Workforce During Crisis

Creating a Resilient Organization

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How Will This Toolkit Help Me?

Learning Objectives

1. Identify common stressors the health care workforce and individual health care workers face before, during, and after a crisis

2. Create a plan for navigating all stages of a crisis in a way that promotes workforce well-being

3. Employ methods to overcome stressors and establish a resilient organization
Introduction

Unexpected crises happen: a pandemic occurs with a new pathogen for which there is no cure, a natural disaster strikes bringing in mass casualties, a nuclear reactor explosion contaminates and sickens an entire region, or some other calamity not yet imagined. Actions taken by your organization before, during, and after a crisis will increase the likelihood your workforce will cope or even thrive.

How do physicians and other health care workers respond to a crisis? Stress may come from 1 of 4 major sources (Figure 1):

- A threat to the worker's personal or family health and life
- A loss of colleagues or threat to professional mastery and identity
- An inner conflict between one's values and aspirations and what they are able to accomplish in their work
- Fatigue, simply feeling worn out by the relentless work and demands, without time for rest and recovery

Figure 1. Four Causes of Stress Injury

<table>
<thead>
<tr>
<th>Life Threat</th>
<th>Loss</th>
<th>Inner Conflict</th>
<th>Wear and Tear</th>
</tr>
</thead>
<tbody>
<tr>
<td>A traumatic injury</td>
<td>A grief injury</td>
<td>A moral injury</td>
<td>A fatigue injury</td>
</tr>
<tr>
<td>Due to the experience of or exposure to intense injury, horrific or gruesome experiences, or death.</td>
<td>Due to the loss of people, things, or parts of oneself.</td>
<td>Due to behaviors or the witnessing of behaviors that violate moral values.</td>
<td>Due to the accumulation of stress from all sources over time without sufficient rest and recovery.</td>
</tr>
</tbody>
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How physicians and other health care workers are supported during a time of acute stress impacts whether they are able to cope and then recover from the crisis, or alternatively, whether they will adopt unhealthy coping mechanisms and show signs of stress injury (eg, burnout, insomnia, dysphoria) or even worse, chronic stress illness (eg, depression, anxiety, post-traumatic stress disorder [PTSD], substance abuse).

Fortunately, progression from a stress reaction to stress injury to a chronic stress illness is not inevitable. Proactive institutional supports initiated before a crisis, "stress first aid” delivered during the crisis, and "recovery aid” provided after the crisis will each increase the odds that individuals will recover and thrive (Figure 2).

Successful organizations take a systems approach and focus on becoming a resilient organization prior to times of crisis, rather than limiting their efforts to a focus on individual resilience or only attending to the well-being of health care workers after crisis develops. Furthermore, resilient organizations need to rapidly reconfigure their well-being priorities to meet the biggest new drivers of stress in a crisis setting.
Figure 2. Conceptual Model: Stress First Aid During and After Crisis Impacts Outcomes

- **Crisis**
  - Personal safety
  - Family safety
  - Overwork
  - Loss
  - Moral adversity

- **Stresses**
  - Anxiety
  - Difficulty focusing
  - Fatigue
  - Loss of coping skills
  - Exhaustion
  - Insomnia
  - Panic
  - Guilt
  - Moral distress

- **Stress Injury**
  - Chief Wellness Officer (CWO)
  - Well-being program
  - Pre-existing “Caring for the Caregiver” plan
  - Communication

- **Pre-existing Institutional Supports**
  - Healthy system
  - Leadership
  - Friends at work
  - Ethics program

- **Measure**
  - (eg, Coping with COVID survey)

- **Stress First Aid**
  - **Basic needs:** PPE, food, hydration, transportation, lodging, childcare, relief of administrative burden
  - **Psychosocial/mental health support:** Peer support, 24/7 mental health, plan for dealing with deaths of colleagues
  - **Communications:** Daily debrief, weekly leadership townhalls, opportunities for input and feedback
  - **Regulatory relief:** De-prescribing

- **No Intervention**
  - **Chronic Stress Reaction**
    - Burnout
    - Reduce or leave profession
    - Depression
    - Substance abuse
    - Suicide
    - Post-Traumatic Stress Disorder (PTSD)
    - Moral injury

- **Recovery Aid**
  - Rest
  - Time away
  - Counseling
  - Reflection to find meaning in work in time of crisis
  - Restoring integrity

- **Recovery and Thriving**
Fifteen STEPS to Care for the Health Care Workforce

Before Crisis: Create a Resilient Organization

1. Appoint a Chief Wellness Officer (CWO) and Establish a Professional Well-Being Program
2. Create a Plan in Coordination with Hospital Incident Command System (HICS) Leadership
3. Support Workforce Needs for Professional Competency During Crisis Reassignments
4. Identify Non-Essential Tasks that Could Be Suspended or Reduced During a Crisis
5. Develop Mechanisms to Assess Stress and Needs Within the Workforce

During Crisis: Support Physicians and Other Health Care Workers

6. Assess the Current Situation; If Necessary, Develop New Crisis-Specific Support and Resources
7. Emphasize and Embody the Importance of Visible Leadership
8. Connect with Other Institutions to Share and Learn
9. Regularly Evaluate Stressors and Stress Levels Within the Workforce
10. Adapt Support Plan to Meet Evolving Needs

After Crisis: Become an Even More Resilient Organization

11. Debrief Unit by Unit as well as by Profession
12. Catalogue What Was Learned and Update the Crisis Plan
14. Honor the Dedication and Memorialize the Sacrifice of Health Care Professionals
15. Resume Ongoing Efforts to Promote a Thriving Workforce
Before Crisis: Create a Resilient Organization

1. Appoint a Chief Wellness Officer (CWO) and Establish a Professional Well-Being Program

With a chief wellness officer and well-being program in place, a unit already exists that can rapidly shift the focus of their work to address the needs created by the crisis event. In crises with significant societal disruption and anticipated psychological stress, it will be necessary for the CWO to partner with behavioral health, communications, and other support services.

In many organizations the CWO is appointed to lead the workforce support response in a crisis since the CWO and their team will have built partnerships or relationships with all these health care system units prior to the crisis. Depending on the nature of the crisis, the CWO may form a task force to help coordinate across many areas, such as providing food, transportation, lodging, security, communications, and behavioral health.

2. Create a Plan in Coordination with Hospital Incident Command System (HICS) Leadership

Assemble a time-limited group charged with identifying the needs of the workforce for the tangible physical, logistical, and psychosocial support needed at work and at home during a crisis. Create a “Caring for the Health Care Workforce Plan,” and work with Hospital Incident Command (HICS) leadership to ensure that the plan includes these dimensions of basic logistical, communications, psychosocial, and mental health support. In creating a plan to support health care workers, be aware that the barriers to seeking and receiving help may be greater among those in the healing professions.

Video: Watch How Rush University System for Health in Chicago Approaches Their “Caring for the Health Care Workforce” Plan

Interdisciplinary Support to Promote Wellness During Crisis

Example from Rush University System for Health in Chicago
There are 2 frameworks that may prove useful as the plan is developed. The first is the Stanford Medicine “Hear me, Protect me, Prepare me, Support me, Care for me” model, and the second is the Mt. Sinai hierarchy of basic needs. Figure 3 illustrates Stanford’s model, and Table 1 covers domains of needs and examples of programs to meet those needs following the Mt. Sinai model. An organization that has cataloged existing resources, identified potential workforce needs, and outlined a plan for how to address them will be a step ahead when a crisis occurs.

Figure 3. Requests Driven by Principle Desires During the COVID-19 Crisis

<table>
<thead>
<tr>
<th>Hear Me</th>
<th>Protect Me</th>
<th>Prepare Me</th>
<th>Support Me</th>
<th>Care for Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to and act on expert perspective and frontline experience. Understand and address concerns to the extent that the organizations and leaders are able.</td>
<td>Reduce the risk of health care professionals acquiring the infection and/or being a portal of transmission to family members.</td>
<td>Provide the training and support that allows provision of high-quality care to patients.</td>
<td>Provide support that acknowledges human limitations in a time of extreme work hours, uncertainty, and intense exposure to critically ill patients.</td>
<td>Provide holistic support for the individual and their family should they need to be quarantined.</td>
</tr>
</tbody>
</table>

Figure 3 adapted with permission from Shanafelt T, Ripp J, Trockel M. Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. JAMA. Published April 7, 2020. doi:10.1001/jama.2020.5893
Table 1. Domains of Need for Workforce Psychosocial Support During a Crisis

### BASIC NEEDS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal safety</strong></td>
<td>• Personal protective equipment (PPE) during a pandemic</td>
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<tr>
<td></td>
<td>• On-site showers, toiletries, laundry services, access to scrubs</td>
</tr>
<tr>
<td><strong>Family safety</strong></td>
<td>• Clear instructions on how to avoid bringing infectious or nuclear contamination home</td>
</tr>
<tr>
<td><strong>Dependent care</strong></td>
<td>• On-site low-cost or no-cost childcare</td>
</tr>
<tr>
<td></td>
<td>• Grant program for those experiencing financial hardship</td>
</tr>
<tr>
<td></td>
<td>• Referral list of local childcare or eldercare facilities</td>
</tr>
<tr>
<td><strong>Transportation and parking</strong></td>
<td>• Waive all parking costs for employees during the crisis</td>
</tr>
<tr>
<td></td>
<td>• Transport assistance (Uber, Lyft) for sleep-deprived health care professionals on rapid cycle shifts</td>
</tr>
<tr>
<td><strong>Healthy food and water</strong></td>
<td>• Food stations in well-being center, in resident's lounge, and in break areas</td>
</tr>
<tr>
<td><strong>Lodging</strong></td>
<td>• Free or subsidized temporary housing nearby</td>
</tr>
</tbody>
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### COMMUNICATION AND LEADERSHIP

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td>• Offer steady, reliable, accurate, and transparent information from leaders about the nature of the crisis as well as the organization's response</td>
</tr>
<tr>
<td></td>
<td>• Acknowledge challenges or deficiencies in the health system's ability to meet the present crisis and clearly state what is being done to correct those issues</td>
</tr>
<tr>
<td></td>
<td>• Be bidirectional: Front line workers need a forum to express their immediate needs and experiences, too</td>
</tr>
<tr>
<td></td>
<td>• Connect through multiple mediums, including email, town hall meetings, video interviews, surveys, comment boxes, and/or 5-minute beginning or end of shift communication with the supervisor</td>
</tr>
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### PSYCHOSOCIAL AND MENTAL HEALTH NEEDS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological safety</strong></td>
<td>• Assure physicians and other health care workers that there will not be professional consequences, such as a reprimand, job demotion, or job loss for speaking up about potentially sensitive topics (ie, honesty about PPE supply issues and fears for personal safety during a crisis)</td>
</tr>
<tr>
<td>Domain</td>
<td>Examples</td>
</tr>
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</table>
| Peer support                  | • Create a peer support program  
• Connect with a peer buddy through a system such as PeerRxMed™  
• Encourage the workforce to consider:  
  ◦ Crisis support group  
  ◦ Moral resiliency rounds  
  ◦ Spiritual practices group  
  ◦ Grief group  
  ◦ Group meditation  
  ◦ Parent support group  
  ◦ Facilitated group reflection sessions  
  ◦ Facilitated pairings  
  ◦ Connectivity or social group sessions (ie, Mayo COMPASS dinners) |
| Partner and family support    | • Provide virtual support sessions to address partner and family concerns, such as emotions as the partner heads to work, fears about contamination when they return, and grief over loss of what they had planned that is now on hold |
| Supportive 1:1 conversations  | • Offer support from a mental health expert, social worker, or other trained volunteer.  
  For example, at the University of Washington, a social worker does an intake and then pairs the health care worker with 1 of the 80 volunteer mental health experts for a supportive and informal conversation. *These sessions are distinct from mental health evaluation and treatment.* |
| Unit debriefs                 | • Consider unit debriefs. Virtual debriefs may work better for physicians and other health care professionals who still feel “on” and in their role at the end of their shift when a debrief would typically occur.  
  One organization found it helpful to offer virtual unit debriefs from home so that team members could choose to listen in, to speak, and to have their camera on or off. The separation and option of anonymity facilitated conversation. |
| Confidential support and referral hotlines | • Dedicated hotline and referral resources specifically for students, residents or fellows, and other trainees may be helpful  
• National Suicide Prevention Line: 1-800-273-TALK (8255) |
| Mental health crisis team     | • 24/7 phone support that can also be deployed on-site for a critical event, such as an employee death |
| Mental health liaisons        | • Behavioral health experts assigned to a cohort who proactively reach out to those at risk |
| Telepsychiatry                | • Confidential access to virtual psychiatric care |
| Self-care                     | • Provide information on self-care techniques  
• Normalize self-care by showing how leaders prioritize these techniques |

Table 1 adapted with permission from Well-being staff resources during COVID-19. Mt. Sinai. Accessed May 1, 2020. https://www.mountsinai.org/about/covid19/staff-resources/well-being
Support Workforce Needs for Professional Competency During Crisis Reassignments

Physicians and other health care workers may need to be reassigned to responsibilities that are outside of their recent practice and comfort zone. This is a substantial source of stress, which can be reduced by communicating that the reassigned health care worker will have the support of the organization to prepare them. This stress can also be reduced by providing the reassigned health care worker with resources before they relocate. The message “you are not alone; we are here to support you” could be reassuring to clinicians stepping into new or unfamiliar roles. A mentoring and training system will help preserve feelings of professional competence. A structure that includes oversight and ready access to expertise is essential.

Patience with onboarding and creating psychological safety are also key. This professional transition support could take one of several forms as outlined in Table 2. These physicians will also need support and understanding of potential medicolegal issues that could arise from their assumption of new areas of responsibility.

Table 2. Professional Transition Support During Crisis Reassignments

<table>
<thead>
<tr>
<th>Examples</th>
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<tbody>
<tr>
<td>Volunteering</td>
</tr>
<tr>
<td>Asking team members to volunteer for redeployment early rather than mandating job changes allows them to rely on their own professionalism to step forward and meet the calling.</td>
</tr>
<tr>
<td>Retraining</td>
</tr>
<tr>
<td>Give redeployed physicians an in-person bootcamp or online training course to prepare them to provide inpatient care. The curriculum could include training videos with tips on how to use the inpatient version of the organization’s Electronic Health Record (EHR). Critical Care for the Non-ICU Clinician by the Society of Critical Care Medicine may be a valuable resource.</td>
</tr>
<tr>
<td>Mentorship</td>
</tr>
<tr>
<td>Redeployed physicians are assigned to a hospitalist mentor and have a transition period rounding with a hospitalist team for several days.</td>
</tr>
<tr>
<td>Teamwork</td>
</tr>
<tr>
<td>Hospitalists lead teams of redeployed physicians and are available for consultation.</td>
</tr>
<tr>
<td>Tele-ICU</td>
</tr>
<tr>
<td>Intensivist support for hospitals where internists are now managing the intensive care unit (ICU). An intensivist at a central referral center has access to the patient records and monitoring data and co-manages the patients with the on-site team.</td>
</tr>
<tr>
<td>Force-multiplier for expertise</td>
</tr>
<tr>
<td>Physicians in high demand specialties due to the crisis reduce the amount of direct 1:1 patient care they deliver to be backups to multiple physicians stepping into areas adjacent to their areas of expertise. This is a “force multiplier” for expertise that is limited and required in greater volume during a crisis.</td>
</tr>
<tr>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>Develop crisis-specific templates and order sets for the EHR.</td>
</tr>
<tr>
<td>Liability</td>
</tr>
<tr>
<td>Extend support and understanding in case medicolegal issues arise because clinicians are assuming new responsibilities.</td>
</tr>
</tbody>
</table>
Identify Non-Essential Tasks that Could Be Suspended or Reduced During a Crisis

During ordinary times physicians may spend as much as 2 hours on EHR and desk work for every hour of direct patient care. This is wasteful at any time; it is unsustainable during a crisis. Physicians often also devote time to numerous other tasks such as annual compliance training, patient satisfaction reports, and, for academic physicians, applications related to promotion and reappointment. Leaders can free up physician time, cognitive bandwidth, and emotional reserve by monitoring changing requirements from The Centers for Medicare & Medicaid Services (CMS) among others, and are taking some of the following steps to lighten administrative burden (Figure 4).

Figure 4. Modifying Policies and Reducing Non-Essential Tasks During a Crisis

<table>
<thead>
<tr>
<th>Teamwork</th>
<th>Administrative</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Permit verbal orders.</td>
<td>• Discontinue non-essential annual compliance and training modules.</td>
<td>• Implement or reimplement transcriptionist services. By some estimates, transcription by a human requires 50% less physician time than manual typing or voice recognition software. This service can be delivered by transcriptionists working from home.</td>
</tr>
<tr>
<td>• Implement crisis-specific standing orders.</td>
<td>• Suspend quality measure documentation.</td>
<td>• Consider novel workforce pools. For example, at some institutions, medical students volunteered to work as virtual scribes*, at others, recently retired physicians returned to practice.</td>
</tr>
<tr>
<td>• Delegate billing or coding to support staff or designated billing team members.</td>
<td>• Stop sending patient satisfaction reports to physicians.</td>
<td>• Simplify EHR documentation with decision support.</td>
</tr>
<tr>
<td></td>
<td>• Suspend dimensions of academic promotion.</td>
<td></td>
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<tr>
<td></td>
<td>• Suspend compensation models or bonuses based on targeted Relative Value Units (RVUs).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Postpone annual performance evaluations.</td>
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</table>

*Any activities involving medical students or other health professions students should be part of a voluntary, student-led program overseen by their school in compliance with guidance from the Liaison Committee on Medical Education (LCME) or other accreditor. No direct solicitation of individual students should occur.

Develop Mechanisms to Assess Stress and Needs Within the Workforce

Understanding the evolving stresses and needs of the workforce will allow leaders to be flexible in meeting those needs. An organization can utilize existing well-being infrastructure to understand the needs of the workforce. For example, the CWO, department well-being champions, and team members can scan for units at risk for moral distress (ie, in a respiratory crisis with a shortage of ventilators the workforce will experience moral distress when triaging limited supplies) to identify the necessary communication and resources to prepare and support health care workers dealing with these issues (Table 3).

I go when I have a gap in my schedule. I’ve been walking through ED and our med-surg and ICU units that have COVID 19 patients and then check one or two other units, time permitting. In the ED, I routinely check in with the attending(s) and charge nurse unless they are busy with other activities. I typically go into a few team rooms and/or talk briefly to teams on rounds to pose the questions below and also do the same with nursing leaders and nurses that I see and who look like they have time to talk.
If people look busy, I typically wave and smile. I have also been routinely thanking many of the medical, nursing, and especially the environmental services and public safety staff that I see for being present and for their contributions. It typically takes me 30-40 minutes to round. When I have less time, I go to the ED and a couple of units and can do this in about 20 minutes. I’ve gone every day that I have been in the hospital (about 6 days/wk) for the last month and have found it to be both enjoyable and a valuable activity. I think people have appreciated seeing our leaders present, especially during the first few weeks when activities and concerns were ramping up.

— Thomas Staiger, MD, Medical Director, University of Washington Medical Center

Table 3. Mechanisms to Assess Stress and Needs Within the Workforce

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Listening sessions</td>
<td>Quickly identify the needs and stresses of the workforce. At the onset of the COVID-19 crisis, Stanford's WellMD Center hosted 8 listening sessions to uncover sources of anxiety. Leaders can also listen for concerns about ethical compromises voiced by members of the workforce.</td>
</tr>
<tr>
<td>Leadership walk-rounds</td>
<td>Gather information, identify concerns, and identify unmet information needs. Walk-rounds can also help identify and resolve operational problems.</td>
</tr>
<tr>
<td>Roll-up communication</td>
<td>Listen for and acknowledge the “voice from the field.” The existing structure of well-being champions in each department and training programs can make it easier to collect and relay the experiences of health care workers on the front lines of the crisis. The findings are then rolled up to senior leadership who can make changes. For example, Mt. Sinai relies on wellness champions who meet weekly with the CWO to present concerns that are in turn relayed to Crisis Communications and leadership to guide messaging and effect policy change.</td>
</tr>
<tr>
<td>Department updates</td>
<td>Hold a brief information session with crisis updates that specifically impact the department’s specialty. Be sure to include time for questions. Invite guest experts to deliver supplemental information.</td>
</tr>
</tbody>
</table>
| Surveys                            | Deploy a brief survey to track stress and its drivers in the workforce or among specific groups of health care workers. The results can help leadership quickly pivot their response and reallocate resources. The AMA created 2 surveys for organizations to assess how health care workers are coping with the COVID-19 crisis:  
  1. A 12-question Coping with COVID-19 for Caregivers Survey designed to be administered every 4 to 6 weeks so that your organization may review change over time  
  2. A 2-question PULSE Survey that can be completed in less the 10 seconds on a mobile device or laptop. This survey can be administered to caregivers weekly. |
Daily huddles

Reconnect to discuss disruptions to the previous workflows and processes, as some crises will require establishment of new clinics, hospital units, and workflows. It can be helpful to schedule time for the work unit to provide input and help refine the work as they do it.

For example, a new respiratory clinic created in response to the COVID-19 crisis scheduled an hour at the end of each day for team members to debrief about what went well and what could be better. This helped improve operations along with team morale.

Creating Wellness in a Pandemic: A Practical Toolkit for Health Systems Responding to COVID-19
Ideas and advice from Rush University System for Health in Chicago

During Crisis: Support Physicians and Other Health Care Workers

Assess the Current Situation; If Necessary, Develop New Crisis-Specific Support and Resources

The most well-intended, meticulous playbook created before crisis may not be enough to meet the needs of the current crisis, which may have been unanticipated and not previously experienced. The CWO and wellness leadership team, potentially with the aid of psychiatry and behavioral health leads, must assess the situation, evaluate the adequacy of the plan, and consider the need to evolve it before deployment. In some cases, it may even be necessary to discard the prior playbook and rapidly develop a new plan to address current needs.

For example, during the first week of the 2020 COVID-19 crisis Stanford held 8 listening sessions with clinicians to surface primary sources of anxiety and fear. Three questions were discussed in each session:

• What are you most concerned about?
• What messaging and behaviors do you need from your leaders?
• What other tangible sources of support would be helpful to you?

Once the sources of anxiety were identified, leaders were able to develop target approaches to support the health care workforce.

Some organizations established respite stations throughout areas where frontline workers were most affected. These stations might include healthy food, water, and reminders of available peer support and mental health services.

If the task force addressing care team needs has a strong mechanism to capture the “voice from the field” and relay them to leadership, incident command, and behavioral health leads who can effectuate rapid change, then this is the way to develop new supports. Organizations may find that most, if not all, of the new resources rolled out during a crisis were based on real and perceived needs ascertained by leaders and the frontline caregivers.
Emphasize and Embody the Importance of Visible Leadership

Leaders at multiple levels within an organization need to be visible to the physicians and other health care workers they lead. Additionally, leaders must be adept at receiving and responding to the needs and concerns of the workforce that come through varied communication channels (eg, in-person, electronic, or virtual). Unmet needs for information can create a great deal of anxiety. The uncertainty inherent in a rapidly changing environment is a significant stressor that can be ameliorated with good multichannel communication that is honest and transparent. The leaders will not always have the answers and in the face of uncertainty should strive to be transparent about what is known, what they can do, and what they are trying to do (Figure 5).

Figure 5. Mechanisms of Leadership and Communication

**DAILY UPDATES**

Daily updates specific to the crisis reassure and empower the workforce with a sense of shared experience and community. Daily messaging reinforces that “we are all in this together” and helps the workforce prepare for expected trends.

For example, during the COVID-19 crisis, daily updates covered the number of patients screened, number who tested positive, and number hospitalized, along with ICU and ventilator utilization and hospital capacity.

**TOWNHALL MEETINGS**

Townhall meetings are an opportunity for leadership to be transparent and respond directly to questions from the workforce—even when they do not have the answers. It is also a time for leaders to express genuine gratitude for the workforce.

During the COVID-19 crisis, the University of Washington held weekly virtual townhalls with leaders. The Chief Medical Officer, Chief Nursing Officer, and the Incident Command leader addressed issues in a conversation moderated by the Assistant Dean for Faculty. The workforce submitted questions (more than 1000 in the first month) that were grouped by theme, then presented to the leaders. Since this was not a presentation prepared in advance, there were times when the leaders did not have the answers, and other times when they were able to explain their decisions and rationale while acknowledging the difficulties they faced. The leaders also shared inspiring stories of patients who were recovering.

**IMPACT REPORTS**

Tracking and reporting information about the health of the workforce in a transparent manner during a crisis can be reassuring. Health care workers can then react and respond to what is happening to their colleagues, and leadership can identify supplemental resources to offer further support.

For example, during the COVID-19 crisis, many organizations tallied and reported the number of team members exposed or who contracted COVID-19 along with their status.
8 Connect with Other Institutions to Share and Learn

Organizations can learn from each other, rather than building all programs from scratch. Existing networks of CWOs or other hospital leaders, professional associations, social networking sites, and other social media can serve as a rapid means of disseminating shared learnings.

9 Regularly Evaluate Stressors and Stress Levels Within the Workforce

It is important to keep a finger on the pulse of stress and anxiety in the health care workforce during the crisis. This assessment should also include assessing the adequacy of support resources and the need for new resources. Accurate assessment can help identify:

- Workers who need a break
- Need for more person-power so additional team members can be brought in
- Areas where support is lacking

Listening sessions, leadership walk-rounds, and pulse stress surveys as outlined in Table 3 can help leaders track the stress levels of the workforce during and after the crisis. Both proactive and reactive means to assess and react to stress are helpful. For example, mental health liaisons can proactively reach out to units under stress and a mental health crisis team is available to react as needed to hot spots of stress.

10 Adapt Support Plan to Meet Evolving Needs

Depending on the duration of the crisis, sources of concern and needs may evolve over time. These sources could include the need for new information (eg, adequacy of PPE, new PPE use guidelines, change in the number of hospitalized patients, fluctuations in number of employees who have developed infection) or new support (eg, childcare when schools close, lodging close to hospital because of increased reliance on rapid cycle shifts). This evolving plan might also include a recognition of the need for a stronger ethics infrastructure to address ethically challenging situations that arise during the crisis. Leaders must continually develop plans to address new and emerging needs.

After Crisis: Become an Even More Resilient Organization

11 Debrief Unit by Unit as well as by Profession

After the crisis it is helpful to continue to support individual health professionals and learn from this experience to be better prepared for future crises. In small group debriefs (hospital work units, specialty divisions, etc) leaders or facilitators can adopt an appreciative inquiry approach, asking, “What went well?” and, “Is there a positive story you can share?” Although stress first aid is an ongoing process, adapting previous approaches can be helpful as the workforce debriefs and reflects on their experience. Examples of other questions to consider reviewing during the debriefing sessions are shown in Figure 6. Offering these sessions as an integrated part of the workday that is strongly encouraged but not mandated may be most effective.
The leader or facilitator may also ask for creative, constructive ideas for ways to improve the unit or profession’s response to a crisis in the future. Finally, the leader or facilitator can ask, “How are you doing personally?”

**Figure 6. Stress First Aid Group Discussion Questions**

<table>
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<tr>
<th>Cover</th>
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<th>Connect</th>
<th>Confidence</th>
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| How has this crisis affected your sense of safety? | What changes have occurred regarding sleep or ability to keep calm? | Has there been an impact on how you connect with others? | Have you noticed any change in your confidence in:  
  • yourself?  
  • leadership?  
  • equipment? |


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### 12 Catalogue What Was Learned and Update the Crisis Plan

Difficult as it is to consider facing another crisis when the current crisis is just subsiding, the odds are that another will develop. It is important to learn from the current crisis while it is relatively fresh. At the same time, the nature of the next crisis is unknown and will undoubtedly bring with it unique needs; this means that no matter how much preparation is done ahead of time, provisions for doing real-time assessment and response will remain critical. The CWO and team can integrate the learnings from the debriefing sessions covered in STEP 11 into the “Caring for the Health Care Workforce Plan” outlined in STEP 2.

### 13 Deploy an Organization-Wide Approach to Support Workforce Recovery and Restoration

Physicians and other health care workers will continue to need help after the crisis subsides to deal with this communal, work-related trauma. Bearing close witness to significant tragedy can have long-lasting effects. In fact, many individuals are able to hold it together during the stressful time but may feel things are falling apart afterward. This time is when recovery aid is helpful (Figure 2). Furthermore, barriers to seeking care may be greater for those in the healing professions than others, so finding ways to normalize recovery aid is also useful. Universal screening for depression and post-traumatic stress can be considered.

It is important to continue to provide confidential and readily accessible emotional, psychological, and mental health support for 6-12 months after the crisis has passed. This may include telephone support lines, virtual visits, and in-person visits. It may also include collegial support groups, which provide an opportunity to find meaning in the tragedy and allow participants to make sense of an intense, uncontrolled period.

In addition, team members may need to be reminded to take breaks during work and to take their vacation time. Physicians and other health care workers may benefit from guidance as to how to re-enter “ordinary time” with their friends and family who have not had such an intense experience.
14 Honor the Dedication and Memorialize the Sacrifice of Health Care Professionals

Recognize health care workers and their families for their incredible efforts. This recognition is part of how culture is built and maintained. Look for physical tokens to recognize these efforts.

Consider a time of remembrance ceremony and a physical memorial for any physicians or other members of your health care teams who have been injured, died, or suffered loss during the crisis.

15 Resume Ongoing Efforts to Promote a Thriving Workforce

The work you and your team had done prior to the current crisis helped sustain the workforce during the crisis. Now it is time to keep strengthening these programmatic offerings. It matters!

Conclusion

Crises are inherently stressful and often involve uncertainty, unpredictability, and increased work intensity. Such events also require flexibility, endurance, equanimity, and professionalism from health care workers precisely when these attributes are most threatened. For health care professionals to successfully navigate these challenges and serve their patients and society during a public health emergency, they need organizational support. How well organizations plan for and support their workforce during a crisis will influence the organization's capacity for patient care, and the personal impact of the crisis on the health care workforce.

Short-term stress has the potential to lead to long-term growth and thriving, known as post-traumatic stress growth, or to long-term stress injury and illness depending on the infrastructure, culture, and actions of an organization. Creating a plan to provide support for the workforce during and after a crisis will help maintain a healthy and sufficient workforce to meet societal needs over time.

It is critical that crisis preparations include plans to support physical, emotional, and psychosocial needs of the workforce. It is also critical for organizations to attend to the well-being of the health care workforce prior to an emergency so that they do not enter times of crisis with a team that is already exhausted, depleted, and burned out. In most cases, the well-being infrastructure that is in place prior to a crisis can serve as the framework to apply new or modified support systems in the midst of an emergency. Taking action before, during, and after will help the organization weather the crisis.

Activity Information

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of 0.50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement: Unless noted, all individuals in control of content reported no relevant financial relationships.
Further Reading

Journal Articles and Other Publications

- New York Times Opinion: The Psychological Trauma That Awaits Our Doctors and Nurses
- JAMA: Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019
- Long-term Psychological and Occupational Effects of Providing Hospital Healthcare during SARS Outbreak
- JAMA: Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic
- Harvard Business Review: That Discomfort You’re Feeling is Grief
- A grounded theory of psychological resilience in Olympic champions
- NEJM: Mental Health and the Covid-19 Pandemic
- AMA News: Peer support program strives to ease distress during pandemic
- AMA News: COVID-19 physician well-being initiatives embrace family needs
- AMA News: Academic health center eases COVID-19 burden with phone triage
- AMA News: COVID-19 front line: Mount Sinai keeps physician well-being in focus
- AMA News: 5 ways organizations can effectively address physician anxiety

Videos and Webinars

- Stanford Medicine COVID-19 CME live and on-demand videos
- Schwartz Center for Compassionate Healthcare: Caring for Yourself & Others During the COVID-19 Pandemic: Managing Healthcare Workers’ Stress
- University of North Carolina Department of Psychiatry: Mental Health and Well Being Survival Guide Webinar
- JAMA interview: Coronavirus (COVID19) Update: Fairly Rationing ICU Care

Websites

- AMA: Caring for our caregivers during COVID-19
- Mt. Sinai: Well-being staff resources during COVID-19
- The Department of Defense: Dealing with traumatic stress
- PeerRxMed™, a free buddy support system developed by Mark Greenawald, MD, of Carilion Clinic in VA
- AMA: Physician health & wellness code of medical ethics opinion 9.3.1

Ways to Share Your Experience

- AMA: Share your COVID-19 story to improve doctors’ safety, well-being
- HERO (Healthcare Worker Exposure Response & Outcomes) Registry
References


3. Shanafelt T, Trockel M, Ripp J, Murphy ML, Sandborg C, Bohman B. Building a program on well-being: key design considerations to meet the unique needs of each organization. Acad Med. 2019;94(2):156-161. doi:10.1097/ACM.0000000000002415


