

ARTICLE

The Evolving Role of the Chief Wellness Officer in the Management of Crises by Health Care Systems: Lessons from the Covid-19 Pandemic

Kirk J. Brower, MD, Chantal M.L.R. Brazeau, MD, Sharon C. Kiely, MD, MPM, Elizabeth C. Lawrence, MD, FACP, Heather Farley, MD, MHCDS, FACEP, Jennifer I. Berliner, MD, Steven B. Bird, MD, Jonathan Ripp, MD, MPH, Tait Shanafelt, MD

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Even before the onset of the Covid-19 pandemic, clinician burnout was a recognized occupational syndrome and a driver of suboptimal patient care. National calls for system-level interventions to improve clinician well-being led some health care organizations (HCOs) to appoint a Chief Wellness Officer (CWO). By incorporating CWOs into the emergency command structure, these HCOs were equipped to identify and address health care worker needs throughout the pandemic. CWOs learned important lessons regarding how HCOs can best address workforce well-being in the midst of a crisis. Key CWO contributions include identifying evolving sources of worker anxiety, deploying support resources, participating in operational decision-making, and assessing the impact of fluid pandemic protocols on clinician well-being. As HCOs seek to promote posttraumatic growth, attention to the well-being of the workforce should be incorporated into emergency management protocols with the goal of sustaining a resilient health care workforce.

Years before the arrival of the Covid-19 pandemic, clinician burnout was recognized as a highly prevalent occupational syndrome that contributes to suboptimal patient care and costly turnover within the health care workforce.^{1,2} In response, the National Academy of Medicine and other professional societies have called for system-level interventions to promote clinician well-being.³ To facilitate successful execution, leading health care organizations (HCOs) have appointed a Chief Wellness Officer (CWO). Distinct from other wellness leaders traditionally found within the realm of HR, CWOs have been tasked with one overriding concern: working to make health care staff

well-being central to organizational culture and strategy.⁴⁻⁷ They do this by using their expertise to measure well-being across their organizations, identifying and advancing individual-level and systemwide interventions to promote workplace well-being, and partnering with other stakeholders to guide the development of such resources.

During the Covid-19 pandemic in the United States, it became clear that the well-being of the workforce was a critical concern. The CWOs at a number of institutions played an important role in understanding and addressing the concerns of the health care workforce.^{6,8,9} This article, authored by CWOs (or those in similar positions) from nine organizations, outlines the role of the CWO in the midst of the Covid-19 pandemic and, on the basis of lessons learned during the current pandemic, provides suggestions to help inform the management of future crises.

Pandemic Phases and the CWO

The start (or first wave) of the Covid-19 pandemic in the United States in early 2020 can be described in terms of four phases: presurge (planning for the onset of community infections and hospitalizations), surge (onset and acceleration of infections and hospitalizations), flattening of the curve (deceleration and leveling of infections and hospitalizations), and postsurge (when infections and hospitalizations reach a graphically noticeable minimal or low level). The first wave in early 2020 has since been followed by subsequent waves at different times across different regions.

During the first wave, two complementary models were used by several of the authors as a guide to understand their observations of HCWs' distress and to implement support strategies. The Stress Continuum Model, developed for the U.S. Navy and Marine Corps¹⁰ and applied to civilians, identifies different categories of stress response with increasing severity as well as associated support options (Figure 1).¹¹

The second model describes stages of emotional response to disasters, described by the Substance Abuse and Mental Health Services Administration (SAMHSA).¹² These are the predisaster, impact, heroic, honeymoon, disillusionment, and rebuilding/recovery stages. Although developed for discrete events rather than a continuing crisis, the SAMHSA model remains conceptually useful. Progression through these stages does not always occur in a linear manner, and an organization may be in several stages simultaneously. Although the last stage of emotional recovery suggests a return to baseline conditions, a more positive perspective emphasizes the potential for posttraumatic growth, defined as positive psychological change after struggling with challenging circumstances, crises, or trauma.^{13,14}

FIGURE 1

Continuum of Stress Model and Support Options

The stress continuum model highlights the fact that people react to trauma in different ways. The color codes are analogous to a traffic light, with green as good to go, yellow and orange as warning lights, and red as stop and remove from the source of trauma. By intervening with progressive levels of support during the yellow and orange zones, it may be possible to prevent illness.

STAFF RESPONSE	READY	REACTING	INJURY	ILL
CONTRIBUTING FACTORS	Health maintenance and energy management	Any stress	Life threat, major loss, exhaustion	moral distress, severe
DESCRIPTION	Well-being and optimal functioning	Mild and transient stress or loss of function	More severe & persistent distress or loss of function	Clinical mental disorders (e.g., posttraumatic stress disorder, depression) or unhealed stress injuries
FEATURES	Physically, mentally, and spiritually fit	Feeling irritable, anxious, down; loss of focus or motivation, trouble sleeping	Excessive guilt, shame, blame; panic; loss of control over emotions; misconduct	Persistent symptoms that worsen over time; severe distress or social/occupational impairment
SUPPORT OPTIONS	Prevention: maintain self-care and resiliency practices	Peer support, psychological first aid or brief counseling	Brief professional mental health treatment and time off for recovery	Extended professional mental health treatment and time off for recovery

Source: The authors. Adapted from the U.S. Navy. Navy Leader’s Guide for Managing Sailors in Distress: The Stress Continuum Model. 2012. Accessed March 5, 2021. https://www.med.navy.mil/sites/nmcphc/Documents/LGuide/op_stress.aspx.¹¹

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Presurge Phase

Before the Covid-19 pandemic materialized in 2020, an emerging literature described preparing for and responding to the psychological effects of previous pandemics on HCWs. Following outbreaks of severe acute respiratory syndrome (SARS) in 2003, for example, the short- and long-term psychological effects on HCWs were well described.¹⁵ SARS differed from Covid-19 in that it did not rise to epidemic levels in the United States, was not as prolonged, infected far fewer individuals, and resulted in profoundly fewer fatalities both in the United States and worldwide. Nonetheless, several correlates of psychological distress were identified that are evident in the Covid-19 pandemic today. These include job stress, burnout, fear of contagion for self and family, periods of quarantine, interpersonal isolation, and redeployment of staff to areas outside of their usual expertise. An important lesson learned during the SARS pandemic was that a perception of

adequate training, protection, and support was a protective factor against later negative psychological outcomes for HCWs.¹⁵

Publications during the presurge phase of Covid-19 in 2020 often included guidelines and checklists to help HCOs prepare for the anticipated surge.¹⁶⁻¹⁸ Appropriately, these initial guidelines were designed to maximize hospital capacity and the ability to provide high-quality care to infected patients, while implementing protective measures to minimize the nosocomial spread of the virus. During the presurge phase in the United States from January through part of March 2020, few articles addressed the psychological responses of the health care workforce to the Covid-19 pandemic,¹⁹ even though the health care workforce was already manifesting high rates of burnout and was stretched to capacity prior to the pandemic.^{3,20,21}

“*An unintended side effect during the pandemic was the distinction that emerged between essential and nonessential staff, including those who could work from home. This led some staff who worked remotely to feel devalued, guilty, and isolated from their peers.*”

In the authors' experience, their health care systems' disaster preparedness for workforce well-being depended on the resources and infrastructure already in place prior to the pandemic. In the HCO of one of the authors, there was a preexisting robust program for workplace well-being, and prepandemic burnout levels were found to correlate with short-term psychological outcomes during the pandemic. These findings further the case that preparedness for protecting the emotional health of the workforce includes attending to well-being on an ongoing basis, not only when a crisis occurs. By strategically establishing a systemwide program of workplace well-being, the organizations represented by the authors were able to pivot quickly — in partnership with their HCOs' operational leadership — to ensure support for their HCWs during the pandemic.²²

Surge Phase

During the first surge in early 2020, HCOs activated command leadership teams (e.g., Hospital Incident Command Systems,²³ Covid-19 Crisis Command Centers, Emergency Operations Teams) to monitor guidelines, directives, and trends from local, state, and national agencies; centralize data acquisition and reporting; efficiently make decisions; establish tracking metrics; implement rapidly changing policies and procedures based on these data and guidelines; manage redeployment of staff; and communicate information to patients, families, and the health care workforce. Providing excellent patient care while prioritizing HCW safety were institutional priorities.

Linking CWOs to command leadership varied across organizations. While one author immediately joined the system-level emergency operations executive leadership team, others were either invited later or had to advocate to join. Some worked with preexisting teams and task forces that had direct connections to their organizations' command leadership teams.

Table 1. The Seven “Cs” of Psychological First Aid

1. Check	Identify and assess staff by observing, listening, and looking for symptoms and loss of functioning that may respond best to the other six Cs.
2. Coordinate	Secure additional help or referrals for staff as needed, including support for basic needs and/or specialized mental health care.
3. Cover	Get staff to a safe location as soon as possible, because a feeling of safety is essential to have a confidential conversation and manage anxiety.
4. Calm	Help staff to relax, slow down, and refocus to reduce anxiety, guilt, shame, grief, and sleep disturbances.
5. Connect	Help staff to get support from others to counter a sense of isolation.
6. Competence	Restore staff’s sense of effectiveness by helping them to draw on coping strategies that they have used successfully in the past to manage distress.
7. Confidence	Build self-esteem, self-compassion, and hope.

The seven themes are listed numerically but are not necessarily intended to be addressed in a linear, stepwise order. Steps 1 and 2 are continuous in nature; steps 3 and 4 are primary aid; steps 5, 6, and 7 are secondary aid. First aid services can be provided by peer volunteers, hospital chaplains, and mental health professionals. They typically are addressed collectively in one session lasting no more than 30 minutes but leave open the option for extended services by referral. Source: The authors. Adapted from the U.S. Navy. Navy Leader’s Guide for Managing Sailors in Distress: The Stress Continuum Model. 2012. Accessed March 5, 2021. https://www.med.navy.mil/sites/nmcphc/Documents/LGuide/op_stress.aspx.¹¹

Delays in including CWOs in the emergency operations leadership teams at times led to barriers in communicating HCW perspectives and needs to those responsible for policy changes. The impact was that messages from executive leaders to HCWs were not always perceived as supportive of HCW well-being. One author’s HCO, for example, increased the number of hours of annual leave employees could carry over to the following year, to encourage them to defer vacation until after the first surge in 2020. However, HCWs interpreted the message to mean that leadership felt they did not need time off. Additionally, HCWs doubted they would ultimately get to take their earned leave. Engagement of the CWO in crafting and communicating changes in leave policy might have led to a different outcome. At another institution, the CWO advocated to executive leadership the importance of messaging that would specifically consider and address the matter of HCW well-being. Subsequently, the CWO was invited to work with the Chief of Communications on the wording of several messages sent by executive leaders. In one organization, the CWO was a member of the daily Emergency Management and Covid-19 Communications Teams. A Daily Covid-19 Alert included updates on personal protective equipment (PPE) and pay practices, coping and other support messaging, and information to access a central call line for emotional and other support and to ask questions.

As the first wave intensified and spread across the country in spring 2020, it soon became apparent that HCWs needed more than PPE and resiliency strategies to maintain professional well-being. CWOs advocated for providing a continuum of psychological support (Figure 1), and many of the authors included models based on psychological first aid principles that had been successfully used in prior disasters,^{24,25} including the U.S. Navy’s Caregiver Occupational Stress First Aid tool (Table 1).^{11,26}

Implementing direct, in-person rounding on frontline hospital units by mental health professionals and/or volunteers trained in psychological first aid for at-risk staff varied across institutions.⁶ Two CWOs supported this during the surge in 2020 by partnering with mental health professionals across the institution as well as with its chaplain service. Another HCO delayed this service while prioritizing others, and others were unable to do it because of insufficient staffing. These rounding encounters provided access, visibility, trust building, and identification of needs and concerns, as

well as opportunities for real-time conversation. In addition, virtual peer and professional support models were used to create space and time for self-care, decompression, and supportive conversations.^{27,28} Virtual care enabled physical distancing and expanded access to services when in-person support was unavailable. The tragic suicide of one New York City physician who had managed a busy emergency department underscored the importance of addressing the psychological needs of all HCWs and emphasized the special needs of those who became ill with Covid-19.²⁹ Accordingly, identification of at-risk individuals and accessible mental health care became key priorities in developing a continuum of support services for HCWs.

“ *Insufficient time or opportunity for self-care, plus the false perception that self-care detracts from patient care, and the ongoing stigma associated with using mental health resources most likely contributed to the underutilization of support resources observed at most of the authors’ institutions.*”

As the pandemic progressed, information from China³⁰ and Italy³¹ emerged regarding workforce experiences and potential needs and strategies to address these needs. In the United States, investigators at Stanford Medicine and Mount Sinai Health System reported that frontline workers had eight major Covid-19–related anxieties: (1) competence in providing necessary care; (2) ability to keep up with the deluge of information; (3) ability to stay safe and keep families safe; (4) access to PPE; (5) access to testing; (6) assistance with personal needs as their workload limited time outside the hospital; (7) access to childcare; and (8) the care their families would receive if they became ill. In response to these anxieties, the Stanford and Mount Sinai investigators identified six requests of health care professionals: hear me, protect me, prepare me, support me, care for me, and honor me.⁸

Using this framework and their evaluations of their organizations’ resources, several authors guided their organizations to facilitate clear, transparent, timely, and bidirectional communications. Achieving this required overcoming the common barrier of suboptimal communication, which is particularly difficult in organizations without centralized communications. Identifying and conversing with the individual or individuals in charge of internal communications is key. Another challenge was to ensure that HCWs felt heard and that they could speak up safely without fearing negative consequences or feeling dismissed. HCOs in general prioritize quality of care and patient safety, so a first step is to focus on making it safe to speak up for patient safety. From there, a pathway exists for speaking up for one’s own safety and well-being.

At institutions where in-person rounds were conducted at clinical sites to provide psychological support, wellness staff also solicited concerns from frontline staff.⁶ This information was then escalated anonymously to leaders for action. Some authors used cross-sectional and longitudinal surveys and/or focus groups to provide a safe venue to learn about HCWs’ emotional reactions and needs. Several authors obtained this information through discussion with a network of colleagues engaged in workplace well-being (e.g., well-being champions or wellness advocates). Information to clinicians and staff was typically disseminated through regular email updates, virtual town hall

meetings from executive leadership, virtual departmental meetings, or team huddles. Several authors were invited to address virtual town halls or meetings and discuss common emotional reactions to crises and resources available. The CWO in several of our organizations became a point of contact for both leadership and staff to raise questions and concerns. CWOs also worked with human resources (HR), finance, and other operational leaders to help provide HCWs with the resources to meet basic needs (e.g., food, lodging, transportation, and childcare) and to ensure timely information flow.

The importance of the CWO providing support to leaders and preparing them to effectively lead their teams through crises cannot be overemphasized. Leaders were expected to remain calm and empathetic, even as they were on-call 24/7; to be responsible for their work teams and patients; to implement new policies that were at times based on incomplete information; and to manage unprecedented fiscal concerns as elective surgeries and radiology procedures were cancelled in the setting of rising expenses.^{32,33} Hartford HealthCare's Behavioral Health Network conducted a research survey administered to the organization during this time. Among leaders, 70.4% reported they believed they managed their direct reports' emotional needs well, but only 56.4% of employees agreed. These findings led the Wellness Department to focus on leadership skills to support leaders and their HCWs. Other helpful strategies that CWOs used to prepare frontline leaders included developing toolkits to support well-being and working on answers to frequently asked questions about supporting their teams and about navigating conversations when a team member tested positive for Covid-19. The CWOs at some organizations, including the University of Massachusetts Medical School, established regular discussion forums at which leaders could discuss their concerns with peers, share ideas, and take away successful strategies for leadership during the pandemic.

Summaries from these listening sessions were shared with frontline leaders to keep them informed about what most concerned their staff and with senior leaders to inform and shape high-level organizational messaging. Participants in these sessions were also asked what messages they had heard from their immediate supervisor/unit leaders that had been particularly helpful, as well as what they had not heard and needed to hear. This feedback was also summarized and shared with all leaders to help them calibrate their own communications.

Health Care Workers as Heroes

HCWs came together to save lives at great personal risk. Their shared sense of purpose and comradery likely helped them to cope with the pandemic.^{34,35} Most organizations demonstrated appreciation for the courageous and sustained efforts of their health care heroes. This was echoed visibly (e.g., signs and billboards) and audibly (e.g., car parades with horns and sirens) in many communities. The accomplishments and recognition boosted confidence, at least temporarily, in individuals, teams, and organizations, corresponding to the SAMHSA honeymoon phase.¹² In addition to clinical accomplishments, however, it was imperative to recognize administrators and all support staff, including, among others, security officers and those from food services and environmental services, who critically contributed to the functioning of the hospital.

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Many providers reported that they did not have time to process their emotions at the height of the pandemic and anticipated needing to do so once they were no longer in survival mode. While such an adaptive response allows them to do the work while compartmentalizing their emotions, the risk occurs that they may deny their feelings or never allow themselves the opportunity to process their emotions.”

An unintended side effect during the pandemic was the distinction that emerged between essential and nonessential staff, including those who could work from home. This led some staff who worked remotely to feel devalued, guilty, and isolated from their peers. CWOs identified this distinction and worked with HR and other stakeholders to develop and facilitate strategies to support at-home and telehealth workers and to offer tips on matters such as avoiding videoconference fatigue. Recognizing the contributions of all health care and support personnel, whether patient facing or not and whether on site or not, proved to be important, because almost everyone’s work and personal lives have been disrupted by the pandemic.

Utilization of Support Services

Insufficient time or opportunity for self-care, plus the false perception that self-care detracts from patient care, and the ongoing stigma associated with using mental health resources most likely contributed to the underutilization of support resources observed at most of the authors’ institutions. We also speculate that the sense of purpose and comradery observed during the earlier phase of the pandemic may have mitigated or suppressed some of the distress staff might have experienced. Hoping to increase utilization, CWOs encouraged communications from executive leaders that normalized and encouraged the use of support services, including mental health services, while reassuring HCWs that confidentiality would be respected. Another strategy included tips for supervisors and managers on how to respond to HCWs about mental health concerns. In-person wellness rounds were a successful example of outreach, by bringing services directly to frontline staff. Finally, health care leaders who served as role models by seeking support and/or sharing stories of their own struggles were appreciated by the authors and their HCOs’ counseling teams.

While underutilization was observed in many organizations, ChristianaCare experienced a 10-fold increase in demand for group support and a threefold increase in 1:1 peer support during the initial surge versus presurge phases in 2020, likely because these support programs were already widely integrated into the institutional culture. Personal resiliency resources were also underused in some HCOs, possibly because support for basic needs, such as providing childcare and food, were more pressing during this time. A survey at Michigan Medicine, for example, reported that only 17% of HCWs replied that resiliency or coping skills training groups would improve their ability to sustain through the Covid-19 crisis, compared with 52% who endorsed access to healthy food at all hours (24/7). Finally, many providers reported that they did not have time to process their emotions at the height of the pandemic and anticipated needing to do so once they were no longer in survival mode. While such an adaptive response allowed them to do the work while compartmentalizing their

emotions, the risk occurs that they may deny their feelings or never allow themselves the opportunity to process their emotions.

Flattening of the Curve Phase

Flattening the curve is a phrase used to describe a steady, rather than increasing, number of new viral-positive cases in a given region or an unchanging number of new Covid-19 admissions to a local hospital. As the community and hospital infection curves flattened, HCWs continued to work at a demanding, even grueling, level, often without adequate time off. The authors observed continued stress and exhaustion as well as increasing hope that the light at the end of the tunnel would soon be seen.

Shanafelt et al⁸ warn, and the authors' experience confirms, that statements of appreciation can sound tone-deaf and increase resentment if they are not paired with actions that demonstrate sincerity. During this phase, it was important that CWOs maintained their advocacy for tangible and emotional support of health care staff as they continued to work through the exhaustion. Tangible support included continued access to essentials: to PPE, to Covid-19 testing with rapid turnaround times, and to one of the vaccines. In the beginning phases of the vaccine rollout in early 2021, HCWs were prioritized, but supplies were uneven, and HCWs still worried about their nonmedical family members and patients. Transparency was helpful, with one HCO sending daily messages about how many vaccine doses were received and how many HCWs had been vaccinated. Other basic needs were 24-hour access to healthy food at work, scheduled breaks, help with childcare and eldercare needs, transportation assistance or nearby parking for fatigued HCWs, and alternative off-duty housing.

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Some institutions also provided support for HCWs who were quarantined because of a potential exposure to Covid-19 or who were recovering from an infection with Covid-19. At the University of Pittsburgh Medical Center, for example, such interventions included members of the wellness team, with consent, calling the isolated colleague to check in regularly, providing resources for psychological support and delivering care packages. By contrast, finding ways to identify and support those in quarantine while respecting personal health information and avoiding Health Insurance Portability and Accountability Act of 1996 violations was a challenge for other institutions.

There were times when HCOs were challenged to provide each of these resources. During national shortages of PPE, for example, managing staff expectations was both difficult and essential as HCOs did their best to provide patient-facing staff with adequate PPE versus their understandable desire for optimal PPE. At one HCO, the CWO led a PPE call-in meeting daily for questions from leaders and staff, which later decreased to weekly as the need decreased. Questions were then communicated to leadership and clarity was provided quickly.

Postsurge Phase

Following the honeymoon phase of the SAMHSA model, typical responses to disasters include a period of disillusionment after the peak of the crisis.¹² We observed this as the number of hospitalized patients with Covid-19 diminished in June 2020, while leadership assessed the fiscal repercussions of the pandemic. Many HCOs quickly transitioned from the medical crisis to a financial crisis because the fiscal strength of their institutions had been significantly compromised. During the initial surge and curve-flattening phases in 2020, only the most medically urgent and emergent non-Covid-19 cases were seen, while telehealth visits were still gathering momentum, resulting in lost revenue from canceled procedures and elective surgical operations.³³ At the same time, the financial costs of care for patients with Covid-19 were significant.³² Some HCOs ramped up patient care operations in order to reduce the backlog of patients whose care was deferred during the surge, as well as to generate much-needed revenue.

Importantly, the CWOs at the authors' organizations helped to anticipate the emotional effects of this inevitable shift toward financial considerations, because stepping up patient care operations occurred almost simultaneously with budget-cutting measures. For example, employment decisions such as furloughs, layoffs, and delays in hiring impacted many HCWs, who suddenly felt devalued, as illustrated by the comment, "We went from heroes to zeros." These feelings were fueled further by increased workloads among remaining staff, who covered for both those who were laid off and their quarantined colleagues. Obviously, those who were laid off suffered significantly from these employment actions. Nevertheless, many remaining coworkers and colleagues reacted with grief from losing their team members, complicated by guilt associated with being spared the job loss that impacted their peers. Likewise, the cohesion and efficacy of some teams were disrupted by the unanticipated loss of coworkers. One author was informed by his HCO's counseling team that more than a few supervisors and HR partners had a need to process their own anxiety after conducting multiple layoff meetings with HCWs. A lesson learned was to anticipate these needs during such times.

The intensity of the sustained stress and human suffering during the initial surge in 2020, coupled with expectations to see more patients with fewer staff, did not often allow the time for HCWs to process their experiences, losses, grief, anger, sadness, and other emotions. During the postsurge phase, these emotions surfaced, and the need for mental health services increased. HCWs still caring for patients with Covid-19 were at risk of experiencing continued emotional drain. Many described the fear of another surge and the anxiety fueled by the uncertainty about the future.

Increased psychological support was offered at all of our institutions, including expanded access to virtual peer support, drop-in support groups, hotlines to seek mental health resources, and

individual sessions with mental health professionals, supplemented in some cases by Internet-delivered cognitive-behavioral therapy for depression, anxiety, or insomnia. Most of the CWO authors worked on developing comprehensive repositories, such as charts or websites to collate and disseminate mental health and well-being resources. The goal of this effort was to centralize a menu of resources to facilitate information and access and avoid duplicative effort (some support services developed in discrete work units); even at this stage of the pandemic, there was still a lack of awareness regarding support resources and leaders still needed to rally to support their employees.

“ *The fact that the Covid-19 pandemic has been universal and prolonged provides an opportunity for a lasting change in how health care organizations support their workforce, even in a postpandemic environment. Engaged individuals and teams working in a healthy organization that supports their needs and well-being is the foundation that leads to optimal patient care and financial success.*”

In some HCOs, communications also shifted suddenly from serving the common purpose of battling a lethal virus and saving lives to overcoming budget deficits. Several of the authors worked closely with the executive communications officer to balance messaging about how the organization was supporting workplace well-being with announcing its plans for achieving financial goals.

At this stage, some of the Covid-19 command operations teams were dissolved with a return to pre-Covid-19 leadership style. Other institutions, such as Rutgers, restructured the command leadership and operations team and included CWOs in the team to deal with postsurge matters and future recovery.

Subsequent Waves

As of early March 2021, many HCOs have reactivated their Covid-19 command leadership teams. Many are also addressing HCW fatigue, and still others are responding to inequities in vaccine distribution. For example, some lower-income HCWs may have lacked the time or Internet access to take early action to book a vaccination appointment. One HCO implemented a lottery system for sequencing individual appointment times. This leveled the field between relatively disadvantaged HCWs and advantaged individuals who knew how to “work the system” to get earlier appointments. Some of the changes in well-being resources that were developed out of necessity will likely be helpful as part of resurgences, eventual recovery, and beyond. Incorporating these resources into the future culture of the workplace represents an opportunity for CWOs to guide HCOs through an institutional version of posttraumatic growth.¹³

The fact that the Covid-19 pandemic has been universal and prolonged provides an opportunity for a lasting change in how HCOs support their workforce, even in a postpandemic environment.

Engaged individuals and teams working in a healthy organization that supports their needs and well-being is the foundation that leads to optimal patient care and financial success.^{2,36}

Special Considerations for Academic Medical Centers

Academic medical centers (AMCs) have the additional responsibility of educating students while protecting them from the virus. Medical students were taken off their clinical rotations and faced anxiety related to both the interruption of clinical training and returning to a more challenging clinical environment. Many residents were at the front line of patient care and were redeployed from regular duties, which added further stress to their work. In addition, researchers lost months of funded research productivity and/or deployed massive efforts to urgently advance scientific understanding of Covid-19. Some CWOs at AMCs were involved in guiding medical educators and residency program directors in supporting well-being efforts deployed for their learners. At the University of New Mexico School of Medicine, the CWO cocreated and cofacilitated two 4-week Covid-19 courses for medical students. The course allowed students to learn about Covid-19 from frontline clinicians and local experts, provided opportunities for students to engage in service projects throughout the state, and created structure and community for the students. Some CWOs included research faculty in their well-being programs.

Lessons Learned and Moving Forward

While the authors' HCOs were challenged by the rapidity with which Covid-19 clinical care requirements and hospital bed capacity needs escalated, it soon became evident that these HCOs, which already had dedicated wellness leadership and associated wellness infrastructure in place, were able to quickly mobilize and deploy resources to promote HCW well-being. A proactive approach to well-being prior to traumatic events lays the foundation for an agile and evidence-based organizational response at a time when resources are strained by an ongoing crisis. It allows the organization to anticipate the needs and concerns of the workforce. While HR departments have multiple responsibilities to the organization and its employees, including their own or outsourced employee assistance programs, the CWO's primary responsibility is to guide the HCO to ensure that it is aware of, and holistically attending to, the well-being of its staff, as well as faculty and learners, at the individual, work unit, and system level.

“*A proactive approach to well-being prior to traumatic events lays the foundation for an agile and evidence-based organizational response at a time when resources are strained by an ongoing crisis. It allows the organization to anticipate the needs and concerns of the workforce.*”

Every HCO has developed emergency plans for narrowly focused crises, such as an infant abduction or a tornado touchdown. The Covid-19 pandemic — an enduring, encompassing, and enervating crisis — has made clear that it is equally important that an emergency plan look out for

the short-term and long-term emotional well-being of employees. Therefore, the creation and rapid deployment of stress resource and response teams, which have been shown to decrease acute and long-term stress responses, are strongly recommended.³⁷ Staff who are not patient facing should also be included in the crisis response to support well-being. For instance, rates of Covid-19 infection and work-related stress in administrative staff and other mission-critical employees, such as food service and environmental cleaning workers, were roughly the same as in frontline HCWs in one study.³⁸

One potentially beneficial consequence of the Covid-19 pandemic is the increased recognition of the importance of workforce well-being and the subsequent funding of research and wellness initiatives by foundations and other philanthropic entities. Adequate funding for studies and interventions to prevent or mitigate clinician burnout, similar to funding that was appropriated after the September 11 terrorist attacks, is urgently needed.³⁹

The CWO is a relatively new role in health care leadership,^{4,5,40,41} and through this pandemic, we have deepened our understanding of its critical role in times of crisis. CWOs with strong connections to command leadership teams can positively impact operations by:

- 1. Playing a critical role in optimizing the organizational response to workplace well-being during a crisis.** This includes ensuring that HCW well-being remains central to HCO operating plans. The CWO develops a strategy for support services and interventions in collaboration and alignment with key stakeholders, including executive and frontline leaders, HR, employee assistance programs, spiritual care, mental health professionals, communications, IT, quality programs, and organizational learning programs.
- 2. Informing the leadership team about which support services are available and which may require development or augmentation to address the well-being of HCWs.** By assessing the support services in operation among all support providers in the organization, as well as their utilization, the CWO can advocate for drawing on resources to meet the wellness needs of HCWs.
- 3. Ensuring bidirectional, clear, and transparent communication between HCWs and leadership.** Having a two-way flow of information between health care staff and executive leaders is key during a pandemic. Leaders require accurate feedback on how their staff are faring, and staff need to feel connected to leadership. The CWO listens to and understands the needs and concerns of HCWs and can provide invaluable information and feedback to leadership about the challenges and stresses happening on the front lines. The CWO also partners with the executive communications team and contributes to messaging by leaders during town halls, which at their best provide a meaningful connection between HCWs and leaders, in addition to accurate information. How messages are worded and their context can make the difference between frustrating and reassuring staff. Moderating the sensitivity, tone, and volume of communications is key, as well as integrating messages of support and hope with operational updates and information. The overwhelming number of communications that staff receive, which can change daily, can sometimes be confusing. The CWO can help contextualize messages. As discussed above, appreciation is best expressed within the context

of meeting basic needs; focusing exclusively on “essential” workers gives a message that lacks inclusivity.

4. **Ensuring immediate support, advice, and consultation as needed to address the changing needs of the workforce during a crisis.** To do so, a CWO must understand the continuum of emotional health and well-being, distress and symptoms, and diagnosable mental disorders that can occur at various stages during disasters (Figure 1). Addressing basic and tangible needs is essential to improving emotional health, especially during a surge (e.g., CWOs can advocate for HCW needs for protection including PPE, 24/7 access to healthy food, safe shelter, and/or reliable transportation). During a crisis, HCW needs are often best met in the work unit.²⁸ At-the-elbow peer support, including psychological first aid with its potential to prevent secondary trauma, is critical during a crisis.^{6,24,25} A CWO can work with others to develop a robust and accessible peer support network with proper training^{27,28} for the inevitable day-to-day stresses of providing patient care during a pandemic. Peer support volunteers can also serve as a communication channel to leadership by sharing their observations of the front lines. The CWO ensures that support services meet the diverse needs of the workforce, while monitoring utilization and satisfaction with them.
5. **Acting to integrate, augment, amplify, and coordinate all support services and wellness resources of various entities across the organization.** Many resources traditionally exist in separated or siloed areas or units within organizations. Examples include occupational health, HR, employee assistance programs, and other entities, each with important and specific roles, contributions, and scope within an organization. During a crisis, these are joined by benevolent efforts from various external and internal resources in support of well-being and need coordination to achieve the desired impact. The CWO can drive existing services further, leverage and open the door to other services, spur meaningful innovation, and provide an evidence-based approach to meet wellness needs. The CWO, together with colleagues, can also help frame, collate, and disseminate organizational resources to help HCWs identify and access the support they need. Providing centralized access to wellness resources and information, such as a single website with links to key stakeholders, can serve this function.
6. **Helping to guide and increase the effectiveness of frontline and executive leaders.** Leaders at all levels require support during times of crisis. Many executive and command center leaders have been working incessantly during the pandemic while exhausted, neglecting self-care, and at times receiving criticism from their workforce. As a member of the leadership team, the CWO is in a unique position to support executive leaders as well as frontline supervisors and managers.
7. **Facilitating the recovery phase of healing and rebuilding with the resolution of the crisis.** The availability and utilization of psychological first aid, peer support, and mental health services during the pandemic have a shared goal of preventing posttraumatic stress disorder, yet some HCWs will have long-term effects.^{15,42} Others will more easily move forward with posttraumatic growth.^{13,14} In addition, the CWO can focus leadership on organizational posttraumatic growth and resilience, imagined as establishing a new normal of

enhanced functioning.¹³ When HCOs revisit their vision statements, missions, and core values, CWOs can ensure that the well-being of both patients and staff is considered.

The CWO Experience During the Pandemic

This article represents a compilation of activities and challenges of this group of authors. Most HCOs could not embody all initiatives. In addition, many of the authors have been in the CWO role for less than 2 years. While some have worked in their organizations for decades, others arrived just prior to the pandemic. The role is humbling to us all. Charged with improving the well-being of a diverse health care workforce was a significant responsibility prior to the pandemic. During the pandemic, the scope of the CWO's responsibilities — which had focused mainly on clinical providers initially — expanded at some HCOs to include all HCWs, nonclinical faculty, and learners, including workforces as large as more than 30,000 HCWs. As the pandemic moved across the United States to different regions, the authors sought support from each other and other CWOs as part of the Collaborative for Healing and Renewal in Medicine Chief Wellness Officer Network. We recognized that each HCO was at a different stage in the journey of institutional well-being. We supported each other nonjudgmentally, and we developed these best practices collaboratively. We appreciate our respective HCOs, which recognized the need for change and created our positions.

Kirk J. Brower, MD

Chief Wellness Officer and Professor of Psychiatry, University of Michigan Medical School, Ann Arbor, Michigan, USA

Chantal M.L.R. Brazeau, MD

Chief Wellness Officer, Rutgers Biomedical and Health Sciences, Rutgers University, Newark, New Jersey, USA

Assistant Dean for Faculty Vitality, Rutgers Robert Wood Johnson Medical School, New Brunswick, New Jersey, USA

Sharon C. Kiely, MD, MPM

Vice President, Chief Wellness Officer, and Associate Chief Medical Officer, Hartford HealthCare, Hartford, Connecticut, USA

Elizabeth C. Lawrence, MD, FACP

Professor, Department of Internal Medicine, and Chief Wellness Officer and Assistant Dean for Professional Well-Being, University of New Mexico School of Medicine, Albuquerque, New Mexico, USA

Heather Farley, MD, MHCDS, FACEP

Chief Wellness Officer, ChristianaCare, Wilmington, Delaware, USA

Professor of Emergency Medicine, Thomas Jefferson University Sidney Kimmel Medical College, Philadelphia, Pennsylvania, USA

Jennifer I. Berliner, MD

Medical Director of the Chief Medical and Scientific Office, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, USA

Clinical Assistant Professor of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania, USA

Steven B. Bird, MD

Clinician Experience Officer and Professor, Emergency Medicine, University of Massachusetts Medical School, Worcester, Massachusetts, USA

Jonathan Ripp, MD, MPH

Chief Wellness Officer and Dean for Well-Being and Resilience, Icahn School of Medicine at Mount Sinai, New York, New York, USA

Tait Shanafelt, MD

Chief Wellness Officer, Stanford University School of Medicine, and Professor of Medicine, Stanford Department of Medicine, Stanford, California, USA

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