

# Envisioning the Future of Well-Being Efforts for Health Care Workers—Successes and Lessons Learned From the COVID-19 Pandemic

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**IMPORTANCE** The National Academy of Medicine's *National Plan for Health Workforce Well-Being* provides recommendations for supporting the mental health and well-being of health care workers. This article aims to guide implementation of National Academy of Medicine recommendations by describing 2 programs at Columbia University Irving Medical Center and the University of California, San Francisco (UCSF), designed early in the COVID-19 pandemic to respond to the behavioral health needs of the health care workforce. The development of these programs, their similarities and differences, and the key lessons learned are discussed.

**OBSERVATIONS** The well-being programs, CopeColumbia and UCSF Cope, shared key elements. Both efforts were led by their respective departments of psychiatry and used similar frameworks. Teams created strategic cross-university partnerships to share difficulties and successes across both programs. Moreover, both programs addressed compounding stressors of racial and political unrest, evaluated program components, and created resources for employee self-management. CopeColumbia and UCSF Cope differed in approaches to identifying high-risk employees and formal assessment and treatment pathways. From the authors' experience implementing these programs and having knowledge regarding health care workforce burnout, this article offers recommendations for the development of well-being programs. These include structural changes and resources to promote group and individual well-being emphasizing equity and justice, intentional involvement of psychiatry on well-being leadership teams, and bold efforts to destigmatize mental health care alongside clear paths to mental health treatment.

**CONCLUSIONS AND RELEVANCE** The impact of the COVID-19 pandemic revealed a need for institutions to support the mental health and emotional well-being of health care workers. By outlining the development and implementation of 2 well-being programs in large academic health care settings and making recommendations to promote workforce well-being, it is the authors' hope that leaders will be empowered to carry forward critical changes. Most importantly, implementing plans now will provide the resilience needed both for the long shadow of the pandemic and future crises.

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**E**ven before the COVID-19 pandemic, high rates of anxiety, burnout, depression, stress, and suicide were increasingly recognized as a growing crisis in the health care workforce.<sup>1-5</sup> The pandemic exacerbated the stress on systems and individuals in health care, amplifying the need to attend to the mental health and well-being of the workforce.<sup>6,7</sup> In 2022, the National Academy of Medicine (NAM) issued a report emphasizing how health care workers have experienced "...extreme mental and physical fatigue, isolation, and moral and traumatic distress and injury,"<sup>8(p1)</sup> and launched a *National Plan for Health Workforce Well-Being*, recommending 7 priorities for health care systems (Box 1)

As psychiatrists involved in creating and implementing workforce well-being programs at 2 large academic health care settings at the beginning of the COVID-19 pandemic, we directly witnessed the mental health toll of this acute-on-chronic exacerbation of stress on

health care workers and their families and the impact of our systems' efforts to address it. In this article, we describe CopeColumbia at the Columbia University Irving Medical Center (CUIMC) and the University of California, San Francisco, Employee Coping and Resiliency Program (UCSF Cope). We outline each program's creation, components, and evolution during rapidly changing conditions. We conclude with recommendations that have resulted from our experiences over the last 3 years and our collective concern about the stakes of the ongoing crises affecting our health care system. These recommendations provide structural suggestions to address the 7 priorities laid out by the NAM *National Plan for Health Workforce Well-Being*.<sup>8</sup> We believe addressing the mental health and well-being of health care workers is a challenge that academic psychiatry departments must actively engage with in partnership with colleagues across health care disciplines and roles.

**Box 1. National Academy of Medicine Plan for Health Workforce Well-Being**

Create and sustain positive work and learning environments and culture.

Invest in measurement, assessment, strategies, and research.

Support mental health and reduce stigma.

Address compliance, regulatory, and policy barriers for daily work.

Engage effective technology tools.

Institutionalize well-being as a long-term value.

Recruit and retain a diverse and inclusive health workforce.

**Initial COVID-19 Pandemic Well-Being Response: Location Matters**

Local conditions shaped our initial experiences and institutional responses to the onset of the pandemic. In late February 2020, the first hospitalized case of COVID-19 appeared in New York, and San Francisco, California, declared a local emergency. By June 2020, New York City registered 395 909 positive test results and 31 909 deaths, whereas San Francisco, California, had 3970 cumulative cases and 52 deaths.<sup>9-11</sup> Health care workers in both cities faced great uncertainty about how they would cope with overwhelming numbers of critically ill and dying patients, inadequate knowledge and resources, and fear for their own and their families' safety. Faculty and staff at our respective psychiatry departments were eager to use their skills to support colleagues during this crisis.

**CopeColumbia**

On March 16, 2020, the Columbia University Department of Psychiatry, with support from the CUIMC leadership, rapidly mobilized a core group of psychologists and psychiatrists who volunteered to provide mental health resources for colleagues across the medical center who were powerfully impacted by the pandemic. They took a collaborative approach, partnering with Human Resources, Faculty Affairs, the Office of Work Life, and others. Early on, the limited knowledge, lack of personal protective equipment, rapidly escalating volume of cases, hospitalizations, and deaths, as well as redeployments of clinicians often outside the scope of prior practice, created conditions of intense fear and anxiety followed by trauma and grief reactions. CopeColumbia's response was shaped by the need to move quickly and flexibly to meet these evolving psychological needs and centered around a model of peer support and education, rather than identification of pathology. The goal was to leverage the diverse expertise of CopeColumbia clinicians with partners across the medical center to provide psychological support, mitigate emotional fatigue, reduce isolation, and enhance resilience. Destigmatizing psychological distress and facilitating access to treatment when needed were important secondary goals. As previously described,<sup>12</sup> support was provided in virtual group and 1-to-1 formats beginning March 23, 2020. In the aftermath of the highly publicized death of a colleague by suicide, CopeColumbia worked with leadership of the Emergency Medicine Department to schedule individual peer support sessions for every faculty member, with the choice to opt out.<sup>12</sup> This model of opt-out peer support was rep-

licated in other departments at times of particularly high stress, with the goal of removing barriers for those unlikely to access support on their own. Educational town hall meetings, grand rounds meetings, and the CopeColumbia website broadened the program's reach.<sup>13</sup>

**UCSF Cope**

On March 24, 2020, the UCSF Health chief medical officer contacted the chair of the Department of Psychiatry and Behavioral Services (DPBS) and the UCSF Health vice president for adult behavioral health and vice chair for the DPBS (author M.J.T.) requesting rapid development of a program to support employees. This vice president had extensive administrative, clinical, and first-hand experience with psychological disaster response during Hurricane Katrina. She built a multidisciplinary steering committee and partnered with UCSF Human Resources and the UCSF Digital Health Innovation Service to design and implement the program. UCSF Cope provided triage, assessment, and treatment services to all UCSF employees across the health care system, regardless of discipline, role, or job assignment. Program designers used a population health approach and technology resources to provide all paid UCSF employees (faculty, trainee, or staff, approximately 30 000 people) with the following: (1) easy, real-time access to curated up-to-date, online, self-management tools; (2) timely access via telehealth to triage, assessment, and treatment; and (3) group-level interventions, including both treatment support groups and nontreatment gatherings of groups experiencing stress related to their unique roles. The program launched April 20, 2020; details regarding reach and use of all UCSF Cope services have been described previously.<sup>14</sup>

**Program Similarities**

In addition to similarities regarding interventions (Table), there were many commonalities, specifically the following:

1. Leadership: Both efforts were led by leaders and faculty members in the departments of psychiatry, which previously had not been directly involved in system-wide well-being efforts.
2. Framework and expertise: Both programs used a conceptual framework emphasizing resilience and stress reduction training, peer support, and normalization of mental health support.<sup>15</sup> Teams marshalled existing departmental expertise in trauma, psychological first aid, grief and loss, and cognitive behavioral therapy-based strategies. Both programs paired the complementary expertise of psychiatrists (who also offered the perspective of shared experiences with medical colleagues from their training) and psychologists (who often brought a more strengths-based perspective in addition to specific therapeutic skills) in clinical intervention design and implementation.
3. Structure and partnerships: Teams initially met weekly and created strategic partnerships with other clinical departments, Human Resources, and employee assistance programs. In May 2020, CopeColumbia and UCSF Cope implemented monthly cross-institutional meetings to process our successes and challenges in addressing well-being, share ongoing efforts and lessons learned, and discuss the compounding stressors faced by our communities. This shared knowledge informed each site's approach and led to joint efforts in creating guidance for man-

**Table. Interventions Delivered by Well-Being Teams During the COVID-19 Pandemic**

Intervention	Description
Pathway to individual treatment	Population-wide screening available via chatbot to identify employees at need for individual treatment. Navigators used to facilitate access to individual mental health treatment.
Peer support individual 1:1 sessions	Designed to provide space to discuss challenges, enhance resilience and adaptive coping, and if needed, refer for mental health services. Faculty or staff call unit and are connected in real time to one of the psychiatry faculty. Facilitator's guide developed using evidence-based practice and updated as the pandemic progressed and new themes emerged.
Peer support groups	Groups consisted of 30- to 60-minute virtual sessions that were department or division specific. Designed to foster team connection and resilience and provide space to discuss shared challenges and coping. Facilitator's guide developed using evidence-based practice and updated as the pandemic progressed and new themes emerged.
Town halls and lectures	These included webinars, lectures, grand rounds, and other educational formats to address department- or division-specific needs. Designed to accommodate larger audiences. Topics include stress, trauma, anxiety, loss and grief, and tips for well-being.
Workshops and panel discussions	Moderated conversations. Examples of panels to date have included <ul style="list-style-type: none"> <li>• Persevering during persistently challenging times</li> <li>• Medical Center faculty and staff sharing experiences related to racial stress and healing (eg, "Bold Conversations")</li> <li>• Tools for managers supporting teams returning to in-person work</li> </ul>
Website and guides	Resources are related to managing stress, fear and anxiety, trauma and loss, parenting, and promoting well-being. Brief tool kits are provided for people in managerial roles on having conversations around challenging topics with employees (eg, holiday stress, political stress, racial stress, return to work stress). In addition, support group manuals were created.

agers, addressing political stress during the November 2020 election cycle (also disseminated as an op-ed<sup>16</sup>), and managing holiday stress.

4. Flexibility to pivot: Both programs addressed concurrent contextual factors including anti-Black and anti-Asian racism, impact of climate change (wildfires), political unrest related to the November 2020 election, and the challenges of returning to work onsite. For example, in the aftermath of George Floyd's murder and the subsequent national focus on systemic racism, CopeColumbia sought to foster space for support and productive dialogue on the ongoing impact of racism within the medical center and launched a very successful series called "Bold Conversations for Healing and Reshaping Our Medical Center Community."
5. Research and evaluation: Both teams used surveys to evaluate activities. Responses were overwhelmingly favorable,<sup>12,14</sup> but there were limitations in the response rate. In partnership with the Department of Psychiatry Physician Mental Health Working Group, CopeColumbia also initiated a 2-year survey-based study of the mental health impact of working during the COVID-19 pandemic. UCSF opted not to collect data about specific users of the services to prioritize privacy and build trust.
6. Dissemination: Both teams created centralized websites with resources for employees to access self-help services and provided some information in Spanish to improve access to all.<sup>13,17,18</sup> The UCSF website also included video shorts and a curated list of mental health apps.<sup>19,20</sup>

## Program Differences

There were also fundamental differences in the approach taken by our 2 institutions, largely related to the differences in magnitude of the pandemic in New York City, and San Francisco, California. CopeColumbia's response was swift but reactive, initially focusing on the health care workforce in high-risk departments (ie, emergency department, intensive care unit), providing acute emotional support to individuals and teams most affected by the massive influx of critically ill and dying patients. As the pandemic continued, the demand for support widened across the system. The mental health treatment needs of patients and the health care workforce also expanded, at times highlighting the limitations of clinical resources.

In contrast, UCSF Cope was able to plan for a broader, population-based approach, considering the needs of all staff and providing institution-wide self-screening and access to care, with special interventions deployed to the highest-risk frontline teams. The creator of UCSF Cope (M.J.T.) had professional experiences—both in leading large health care systems and with disaster psychiatry—that prepared her to view problems with a population-health lens. UCSF Cope provided a single universal pathway to formal assessment and treatment, including for "hidden" frontline health care workers (eg, custodial services and food services)<sup>21</sup> via creation of the UCSF Cope Conversa Digital Chatbot Screener. This screener was accessed by text, online, or QR codes and widely distributed. It used an algorithm to differentiate acuity based on self-reported symptoms and directed users to tailored web resources on stress and mental health for mild to moderate symptoms, a live health navigator for moderate to severe distress, and prioritized access to mental health services for those with exacerbation, relapse, or onset of a new illness. Those endorsing immediate risk of self- or other harm or self- or child endangerment were directed to emergency services.

## Current Status of the CopeColumbia and UCSF Cope Programs

Over the subsequent 3 years, both programs evolved in response to transitions in the pandemic and the needs of the institutions, funding and availability of resources, and leadership transitions. The UCSF DPBS partnered with UCSF Health and a gracious donor to fund clinicians providing UCSF Cope services. Currently, the program is in the process of transitioning to institutional-level investment and oversight, with critical discussions about how to sustain key elements of this program. Similarly with new executive leadership, CUIMC established an Office of Well-Being, and one of the founders of CopeColumbia, Clinical Vice Chair Lourival Baptista-Neto, MD, was inaugurated as the first chief well-being officer. CopeColumbia continues to provide individual and group support, educational activities, and the "Bold Conversations" discussion series with financial support from CUIMC under the auspices of this larger centralized well-being office.

## Lessons Learned

### Plan for a Future Crisis

Institutions must start planning now for a future crisis. Notably, neither institution had previously integrated mental health or workforce well-

being into disaster planning, nor was either program prepared for the breadth and duration of the crisis. In addition to building a robust well-being program, health care systems must incorporate explicit plans for supporting mental health into future disaster preparedness.<sup>22</sup> These plans require investment in a mental health workforce that has capacity and flexibility to respond during disasters.

### Implement Structural Change

Institutions must implement structural changes to promote well-being and improve the lives of the workforce. Workplace well-being is largely dependent on structural factors. After the initial shock of managing the fear and uncertainty of a novel deadly virus, we found that sessions emphasizing individual well-being and coping strategies without adequately addressing (or at least acknowledging) structural barriers to wellness evoked negative responses. For example, the impact of lack of childcare resources clearly impacted health care worker experience of burnout during the pandemic.<sup>23</sup> As we have described previously, "Any serious plan to prepare for future disaster must address the preexisting systemic factors that contribute to chronic stress, including inadequate staffing, inefficient electronic medical records that prioritize billing over patient care, schedules that do not allow for adequate sleep, leave policies that are unsupported of families, disinvestment in nonbillable support crucial to good outcomes (such as social work), and a culture of unrealistic expectations."<sup>22(p1822)</sup> Attention to these issues (or not) creates workplace environments that either mitigate or exacerbate the inherently stressful jobs involved in caring for ill patients.

### Institute Compassionate Leadership

Compassionate leadership is a key component of positive cultural change in health care institutions. In the initial crisis and through the waves of medical, environmental, and social stress that have followed, the central role of leadership in creating a sense of safety and shared purpose was repeatedly highlighted—not only at the top but across all layers of administration. We created written and video resources for managers, recognizing managers' roles in bidirectional feedback with leadership and workforce teams, and their responsibility for implementing policies that can promote (or detract from) workforce well-being.<sup>24</sup> We believe that leaders should obtain training in compassionate leadership following the principles of trauma-informed care: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and attention to culture, historical, and gender issues.<sup>25</sup> We believe that leaders should be evaluated by their ability to prioritize well-being and mental health, in addition to productivity.

### Allocate Dedicated Resources

Institutions must allocate ongoing dedicated resources for health care workforce well-being. Both systems in the initial phase of the crisis mobilized clinicians eager to volunteer time to support their colleagues to rapidly create these programs. However, as our medical centers reopened, it became clear that meeting the varied needs of workers across complex health systems requires ongoing investment from the larger institution, rather than relying on individual volunteers or departmental resources. Given that the mental health workforce also experiences burnout, well-being programs require financial and personnel resources, including protected effort for a

dedicated team of diverse clinicians, leaders, and administrators. Effort for various interventions delivered by faculty or staff (eg, town hall meetings, small groups) should be compensated to ensure their sustainability.

### Promote Equity and Justice

Equity and justice within institutions are essential to employee well-being, and population health approaches can address inequities. The disproportionate toll of the COVID-19 pandemic on historically racialized and economically marginalized populations is well documented. Clinicians caring for these populations are faced with the consequences of societal inequities that limit their ability to care optimally for patients and contribute significantly to moral injury. Within the health care workforce, the stresses of the pandemic were also unequally experienced. For example, productivity declined among women compared with men in academia.<sup>26-28</sup> Black workers and other racial and ethnic minoritized groups experienced tremendous racial stress related to the pandemic and particularly in the aftermath of the murder of George Floyd. In our experience, it was harder to reach hidden frontline workers (eg, phlebotomy, nutrition, and environmental support staff). These staff roles are overrepresented by women and historically marginalized racial and ethnic groups. Well-being efforts must go beyond verbalizing a commitment to equity and implement population health approaches to reach all workers. Institutions must work on practical steps to change the culture and promote safety for all employees. Programs such as CopeColumbia's "Bold Conversations" can help foster open discussion as can community affinity groups, which have a strong evidence base to promote well-being and resilience.

### Establish Psychiatry Leadership

Psychiatry must be part of the well-being leadership team. We strongly believe that psychiatry should hold a formal role within any system-wide well-being effort in health care. Because well-being exists along a spectrum, our programs benefited from psychiatry leadership who could facilitate consideration of the range of mental health issues that often co-occur with significant work stressors and burnout, integrate evidence-based therapeutic approaches into well-being efforts, and facilitate access to clinical care. Furthermore, the exclusion of psychiatry and clinical psychology from well-being efforts may unintentionally contribute to stigma around accessing psychiatry services. Although palpable competition for ownership of the well-being space exists, we suggest reframing these efforts to be a partnership of people with diverse contributions of strengths and expertise.

### Launch Essential Partnerships

Partnerships and trust are critical for successful well-being efforts. Human resources groups were key partners in both institutions and must be engaged early in any crisis response. Collaboration between departments and units, such as Faculty Affairs, the Office of Work Life, employee assistance programs, as well as between academic and hospital programs that have historically functioned in silos, were critical to our successful efforts to support well-being, build trust, and overcome stigma. Partnerships should also be encouraged across institutions, as exemplified by our mutual sharing of experience and efforts that benefited both programs.

**Box 2. Key Lessons Learned**

Institutions must start planning now for a future crisis.

Institutions must implement structural changes to promote well-being and improve the lives of the workforce.

Compassionate leadership is a key component of positive cultural change in health care institutions.

Institutions must allocate ongoing dedicated resources for health care workforce well-being.

Equity and justice within institutions are essential to employee well-being, and population health approaches can address inequities.

Psychiatry must be part of the well-being leadership team.

Partnerships and trust are critical for successful well-being efforts.

Institutions must create a path to mental health treatment for all employees.

Institutions must take steps to destigmatize mental health support and treatment.

addition to individual treatment, employees should be able to access a range of resources for self-help and stress management.<sup>17</sup>

**Destigmatize Mental Health Support**

Institutions must take steps to destigmatize mental health support and treatment. Many interventions intentionally focus on burnout—rather than mental health—to avoid the stigma associated with mental illness and highlight systems-level etiologies.<sup>29</sup> However, there is significant overlap in work-related and non-work-related predictors of burnout and depression.<sup>30</sup> We recommend that institutions launch mental health destigmatization campaigns to encourage all staff to seek treatment when needed, connected with scalable low-resource interventions.<sup>31</sup> Hospital privilege processes should not include any questions regarding mental illnesses or treatment, but rather focus on current ability to perform occupational duties.<sup>32</sup> Throughout the pandemic, both of our institutions directly addressed the issue of stigma in seeking mental health care.<sup>33,34</sup> Modeling open discussions of mental health by leaders is powerful.<sup>35,36</sup>

**Create Employee-Focused Opportunities**

Institutions must create a path to mental health treatment for all employees. Institutions could consider using a population-health model leveraging tools like the UCSF Cope Chatbot and should build trust with partners representing employee interests to ensure the ability to collect data that will facilitate future targeted interventions. To increase employee access to mental health services in ways that provide reassurance about confidentiality, institutions should consider contracting with insurance providers with robust mental health coverage and/or partnering with companies that have remote telemental health and facilitate care for employees and their family members to be delivered both within and outside the medical center. In

**Conclusions**

The COVID-19 pandemic highlighted challenges and demonstrated both the critical importance and vulnerability of mental health in health care.<sup>8,37</sup> Implementation of recommendations to support health care workers will require significant resources at the local, regional, and national levels. We strongly believe that implementation efforts for both healing existing burnout and prevention must begin now. We hope that health care leaders will take this opportunity and re-envision how we work and ideally carry forward the key lessons that we have learned the hard way (Box 2).

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