All Hands on Deck: Board Support of Employee Wellness in a Time of SARS-CoV-2

By Linda Brady, M.D.

Key Board Takeaways

Boards will need to take action to address the inevitable employee burnout and wellness concerns caused by SARS-CoV-2. Boards can begin by asking the following questions:

- What are the inequities that our staff and workforce face in their communities and lives? What is our role to address these?
- What are we doing to protect the physical and emotional health of our employees?
- Do we have someone designated as a wellness officer? If so, is that individual an integral part of the crisis response team?

Prior to SARS-CoV-2, the 21st century ushered in severe acute respiratory syndrome (SARS, 2003), H1N1 influenza (2009), Middle East respiratory syndrome (MERS-CoV, 2012), and the Ebola (2014–2016) and Zika (2016) viruses. Each has its unique features and prescriptions for prevention, containment, and treatment. The United States was largely spared, therefore never fully testing the systems and preparatory measures that need to be in place.

While we should have comprehended the day would assuredly arrive when the United States would not go unharmed, most hospitals and health systems were not fully prepared for the current SARS-CoV-2 pandemic. Healthcare institutions and their fiduciaries must now directly address and prepare for the enormous emotional toll blanketing healthcare workers as a universal sequela of this pandemic.

Health of the Workforce

Burnout prevention and wellness promotion is a serious issue that healthcare leadership teams have been grappling with and responding to through education, research, and calls for action. Documented is the increasing prevalence of symptoms of burnout among healthcare workers (e.g., emotional exhaustion, depersonalization, and lack of a sense of personal accomplishment). The consequences for healthcare organizations include increased rates of staff disengagement and turnover; staff shortages; lower staff satisfaction, morale, and patient experience scores; and at the far end of the spectrum, risks to quality and patient safety.[1] In recognition of the essentiality of healthcare workers and the quality of their experience, the Institute for Healthcare Improvement added a fourth aim, the joy of work, to the well-established Triple Aim.[2]

Staff stress and burnout predated SARS-CoV-2, but this has served as an accelerant, placing the matter in sharp relief. Many, if not the majority, of our healthcare workers are confronted with unprecedented levels of suffering and loss—of their patients, colleagues, friends, and families. In order to protect their loved ones from the risk that they pose as caregivers of COVID-19 patients, many are choosing to isolate themselves, thus compounding their experience of loss, stress, trauma, and exhaustion. In public health terms, this is a pandemic within a pandemic.

Early on, institutions, local and state governments, and industry associations in the most highly affected regions advocated, competed, and, at times, publicly pleaded for supplies of protective patient equipment (PPE), ventilators, testing capacity, and staff. Not having the tools and resources needed magnified employees' feelings of uncertainty, confusion, fear, and stress, and left them feeling powerless.

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While this crisis has disrupted the healthcare industry and those who work in it, it can also serve as an opportunity for seismic shifts in organizational culture. Even the most well-performing organizations can seize this chance for improvement. Crisis requires leadership that is agile and adapts to circumstance. It calls for "all hands on deck," and the board can best lend its hand through active participation, guidance, and oversight (for example, listening to employees, gathering their feedback, working with management to uncover issues, and creating an action plan for implementing positive changes, as discussed more in this article).

Common Threads: Transparency, Communication, and Engagement

In interviews I conducted with eight healthcare professionals (including physicians, nurses, and board members) about their experience during this time, the need for transparency, widespread communication, and employee participation in decision making were recurring themes. While forever valuable, these approaches can provide an indispensable and secure anchor particularly in the initial stages of a crisis when varying degrees of upheaval, confusion, and shifting information accuracy permeate the organization.

Widespread, frequent, and candid communication throughout the organization led by the CEO is key. The board requires it, as do employees. It is a reassuring framework that fosters trust and minimizes disruption. An integrated strategy of response must include a communication plan that complements but does not overtake or interfere with the needed mode and speed of intervention to the crisis at hand. As well, the board's role is not meant to supplant that of management but rather to be identified as that of the torchbearer for the overall direction of the organizational response.

The Equity Gap Affects Hospitals Too

Embedded in staff stress and burnout is the matter of inequity and disparities. The inequities in the social determinants of health have been laid bare by this

1 Thomas P. Reith, "Burnout in United States Healthcare Professionals: A Narrative Review," *Cureus*, December 4, 2018.
2 Jessica Perlo et al., *IHI Framework for Improving Joy in Work,* Institute for Healthcare Improvement, 2017.

pandemic: discrimination, gaps in healthcare access, economic stability, education, housing, and food security have placed Black, Latinx, and other historically disadvantaged populations at disproportionally greater risk of infection and death from the virus. Also exposed are the preexisting social vulnerabilities to the health of workers in healthcare organizations.

We may all be in the same storm, but we are not in the same vessel; some have ships and some have rowboats, revealing the vastly different experiences and outcomes for the "have" and "have nots" of the healthcare workforce in this pandemic. I provide a thumbnail sketch of the experience of frontline providers from two New York City hospitals, a "have" and "have not" facility. Both hospitals are members of large health systems—one well-positioned financially; the other not.

The "have" institution had, either through inventory or the ability to obtain it, relatively adequate supplies of PPE, the financial means to hire costly travel nurses, and per diems to staff for the surges in demand for critical care beds. Staff shortages or absences due to illness were not widespread. Stress and disruption, although unquestionably present, appeared, at least on the surface, contained.

The "have not" institution did not have the same elasticity and suffered major shortages of PPE and staff with higher occurrences of illness and absences due to COVID-19, thus compounding the staff shortage problem. One provider with whom I spoke had contracted COVID-19 and was unable to be tested by their place of employment. Due to staff shortages, this provider felt pressure to return to work before being fully recovered. The sense of uncertainty and fear was more palpable, as was the perception that the system could have better supported its affiliate.

These thumbnail sketches are just that, and are not meant to generalize but rather highlight the need for in-depth case studies from which we all can learn and benefit.

On a macro level, these reports offer a distinctly different experience, yet both organizations cited significant opportunities for improvement in processes reflective of the common threads cited previously: transparency, communication, and employee engagement.

In my New York City experience, "have not" institutions generally serve a greater proportion of socioeconomically challenged minority communities with concomitantly high percentages of Medicare and Medicaid coverage relative to the higher-reimbursing third-party insurers. Frequently, these communities suffer the health disparities associated with inequities in the social determinants of health. Considering that healthcare institutions are among the largest employers in a community, it stands to reason that a meaningful number of the employed healthcare workers live in the surrounding community served by the organization. Of import for future study is a comparison of the rates of illness, morbidity, and mortality of workers in hospitals that serve communities with a higher incidence of social determinants of health inequities and resultant health disparities. How might the rates of illness among hospital employees, principally those at the lower end of compensation, job security, and power, mirror that of the community?

While in the midst of this pandemic, regardless of where your community lies on the spectrum of viral transmission and activity, there is still time to listen, incorporate knowledge gained, formulate an action plan, and prepare for what lies ahead—whether it be this or the next crisis.

Board Actions and Takeaways

As boards lead their organizations through this pandemic, they should commit to an initiative to strengthen and improve the organization and its culture by incorporating lessons learned from this crisis into a strategic action plan. To do this, they can use tools presently in the board toolbox:

- Have the board committee responsible for quality oversight invite representatives of provider/employee focus groups at all levels of the organization to meetings to listen and learn from their experiences and consider implementing their recommendations.
- Obtain board education about experiences and lessons learned from other organizations within and beyond healthcare; for example, the successful interventions undertaken to care for short- and longer-term physical and mental health needs of the heroes of 911.
- Request a culture of safety survey be conducted whenever feasible for feedback from providers and employees.
- Conduct a blameless root-cause analysis of significant problems uncovered to determine the fundamental elements around which change is to be centered.
- With management, formulate an action plan to implement the changes.
- Communicate the plan to employees and provide an opportunity for feedback.
- Incorporate the final action plan into the board strategic planning process.
- Communicate the finalized plan to providers/employees.
- Measure success.

In conclusion, I paraphrase a provider from one of the "have" organizations: while the frontline heroes appreciate the recognition and appreciation heaped upon them, it will ring empty without a bona fide debriefing and implementation of true solutions in response to lessons learned.

The Governance Institute thanks Linda Brady, M.D., Former President and CEO of Kingsbrook Jewish Medical Center in Brooklyn, NY, for contributing this article. Dr. Brady is currently a consultant whose interests center on issues of governance. She can be reached at lbradykjmc@aol.com. The author would also like to express her sincere appreciation to the individuals who gave their time and candor for the interviews that helped shape this article.