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The Impact of COVID on the Mental Health of Health Care Providers

Introduction

Isabelle Davis sat at her desk in June of 2020 and reflected on a critical issue: the mental health and well-being of the clinical workforce at Mountain View University (MVU) Health. Since becoming the dean of the School of Nursing at MVU Health in the fall of 2019, she had been trying to get her arms around efforts to support clinician well-being at MVU. Davis had spent the last three years working on a focus group at the National Academy of Medicine on clinician well-being and burnout, and she was a member of its task force dedicated to this issue. The COVID-19 pandemic added a new stressor to the lives of clinicians, including doctors and nurses, so Davis had been charged by MVU Health leadership to develop a plan for the health system.

Background

The COVID pandemic exposed the urgency in addressing clinician well-being in the United States and around the world, as health care team members suffered the impact of an unrelenting surge of deaths and oppressive working conditions. Not only were clinicians working extraordinarily long hours, weighed down by uncomfortable protective equipment, but they were also burdened by feelings of inadequacy and hopelessness as they risked their own lives and the lives of their families to stem the effects of the COVID-19 virus. Their stress was unabated, and many experienced despair and desperation. Even worse, many felt unable to ask for help to alleviate their suffering, seeing it as a sign of weakness. The ongoing moral injury and emotional stress were destructive and led some to leave their professions or even take their own lives. Prevention of these devastating effects was crucial, so that not one more life or career would be lost to the emotional and mental health pandemic that was descending on clinicians.

Prior to the COVID-19 pandemic, the health care community, led by the National Academy of Medicine, had identified clinician burnout as a national public health crisis. Much of the cause of this burnout was attributed to environmental factors, including the impact of the electronic medical record (EMR) on practice, loss of control over resources, and volume-based employment contracts. Now, the pandemic layered additional stress on an already burnt-out workforce.

National efforts had focused on addressing the regulatory issues that drove dissatisfaction, such as burdensome documentation, in order to restore time as well as autonomy to clinicians. Other major areas requiring attention included systemic changes to improve the working and learning environment, including support for clinicians and learners.

This disguised case was prepared by J. Corey Feist, Lecturer, Darden School of Business, and CEO, UVA Physicians Group.

Ensuring that clinicians would seek the support and care they needed could be elusive and was often fraught with stigma, especially if the care was psychiatric. Despite help being confidential, a number of barriers constrained professionals from seeking help. These included

- Self-imposed pressure that could lead to a sense of failure
- Fear that disclosure could lead to loss of license and ability to practice
- The prospect that confronting the problem could lead to treatment that was not appealing
- Overall stigma associated with seeking mental health care
- Denial of substance use issues or other mental health conditions

Left untreated, severe stress, emotional, and behavioral health issues affecting clinicians led to burnout. This could have serious consequences, including emotional exhaustion, depersonalization, lack of personal accomplishment, and negative impacts on patient care. In extreme cases, burnout could lead to errors with patient injury and clinician suicide. Even prior to the pandemic, one physician each day had died of suicide.

Opportunities at MVU— Investing in Clinician Well-Being

MVU Health was an academic medical center in a rural town in the mid-Atlantic region with annual revenues of $2.5 billion and a healthy balance sheet. MVU Health had three missions: teaching, research, and clinical care. It was made up of a 700-bed Medical Center, a School of Medicine, a School of Nursing, and a Medical Group. MVU Health employed over 1,000 full-time physicians, 2,500 professional nurses, and 8,500 full-time staff.

In 2010, MVU Health implemented an EMR system, which was an ongoing source of strain and dissatisfaction for its physicians. In fact, in a recent survey of clinician satisfaction with the EMR, the MVU Health doctors reported a 17% satisfaction rate with the EMR, compared to the national average of 60%. The survey results contained a number of themes that MVU Health had begun to tackle, including a lack of training, inefficient clinical work flows, and added time, known as "pajama time," documenting care before and after normal work hours. Certain areas within MVU Health had addressed these issues years earlier by hiring scribes to perform documentation tasks for the physicians during patient exams. The use of scribes was well received by those physicians who could afford to hire them, and who were usually in the more lucrative clinical departments such as orthopedic surgery and emergency medicine. Unfortunately, this represented only about 30% of the total physician workforce, as the vast majority of clinical departments could not afford the overhead.

Among other efforts to respond to the EMR survey results were a new training program for existing physicians to optimize the use of the EMR and an effort to pilot customized changes to the EMR to improve practice efficiency in one department.

One of the most successful efforts to date was focused on redesigning the primary care outpatient clinics to a team-based care model. In that team model, processes had been redesigned to cross-train medical assistants, whose primary responsibility previously had been limited to bringing patients into the exam rooms and taking their height, weight, and blood pressure. Under the team model, the medical assistants expanded their roles to take on scribing responsibilities as well. After the first year of the team model, the primary care physicians had decreased their pajama time by 30% and increased the number of patients they could see on a daily basis by 25%. The model did have its financial downside, as the cost of the additional staff exceeded the additional revenue the physicians could bring into MVU Health. As a result, the team model was used in only about 5% of all MVU Health outpatient clinics.

Another contributor to physician stress at MVU Health was performance-based employment contracts. Compensation plans generally contained two components: base salary and an incentive. The compensation for procedure-based specialties tended to have a larger incentive component based on productivity, whereas the less procedurally focused physicians tended to receive more of their total compensation through a fixed salary that did not vary based on productivity. While these contracts added to the stress of the physicians, they had become the industry standard, and MVU Health leadership increasingly relied on them to drive financial margins. In a recent analysis by MVU Health leadership, the physicians with more productivity-based compensation drove a financial return to MVU Health that was 50% greater than that of physicians with a fixed salaries.

The current infrastructure to support the mental health of the workforce at MVU Health was focused in two areas: the employee assistance program (EAP) and a provider wellness program called "We Are Wise." Both programs provided confidential counseling services when requested by the employee, physician, or that individual's supervisor. EAP served more of the needs of the non-physicians, whereas We Are Wise was more focused on the physicians. In addition, MVU Health had run multiple educational programs focused on mindfulness as a stress-reduction strategy. As Davis learned more about the use of the support programs, she was surprised to learn that both programs had more capacity than was being utilized. MVU Health doctors, like their national peers, cited stigma and professional ramifications on their licensing, despite the fact that the programs were confidential. As COVID hit, Davis started to promote this excess capacity to the MVU Health workforce through daily emails. While this helped, Davis felt there remained an unmet need.

By June, the volume of COVID patients at MVU Health remained small compared to hospitals in major metropolitan areas such as New York City, New Orleans, Detroit, and the Washington, DC, area. Nonetheless, the pressures associated with planning for the pandemic, evolving practice standards to treat COVID and non-COVID patients, coupled with a steep financial decline for MVU Health, had impacted all providers and staff. MVU Health had been dedicated to the COVID effort since early March, and as the summer months arrived, there was hope the volume of COVID patients would decrease. Providers were showing signs of stress and burnout; many would stop Davis in the hallway to share their issues and ask for support.

Davis sat at her desk reviewing the draft outline of a proposal for clinician well-being at MVU Health, which she had begun the night before (**Exhibit 1**). A report from the United States Medical Association (USMA) survey of burnout dated June 1, 2020, was open on her desktop—the national average of clinicians reporting burnout was 68%. Local data were available only for those institutions that participated in the free USMA survey, and Davis had not yet obtained approval from MVU Health leadership to participate in it. One executive had remarked, "We already know they are stressed, but COVID hasn't really hit us that hard. Why do we need to ask them in a survey?" Davis struggled. If she could not convince leadership to approve participation in the free survey, how could she convince them to spend any new program dollars?

Questions

1. Given the impact of COVID on the mental health of health care providers, what should Davis recommend the response be for MVU Health?
   a. What are the most important factors Davis should consider in developing her response?
   b. How should she address the issue of the low volume of COVID patients?
   c. How should she address the cultural stigma of seeking mental health support by physicians?
2. How should Davis make the case for her recommendations?
3. What key performance indicators should Davis use to monitor the impact of the recommendations?

Exhibit 1

The Impact of COVID on the Mental Health of Health Care Providers

Draft Memorandum: Proposed Clinician Well-Being Program

[DRAFT 6-15-20]

To: Executive Vice President, MVU Health

From: Dr. Isabelle Davis

Re: Proposed Program for Clinician Well-Being

Date: June __, 2020

A. PREVENTION PROGRAM:

1. **Stress First Aid and Peer Support** is designed to promote the resilience of caregivers, strengthen team cohesion, promote peer intervention, and support unit -level assessment and consultation of the occupational stress environments of caregivers. Well-being and Peer Support is intended to support increased job satisfaction, higher retention, and increased caregiver preparedness for occupational demands.

   The three core objectives of this program as outlined in reference(s) are:

   - Early recognition of caregivers in distress.
   - Peer intervention.
   - Early connection with services as needed.

2. **Well-being unit level and individual level program offerings**. These include skills workshops on effective communication, difficult conversations, and practices to enhance positive culture, mindfulness, and full and short courses.
3. Critical incident training and support:

   a. *"When things go wrong"* training program: proactive training in talking with families, patients, and employees when an error occurs.

   b. *"Stepping in"* training program: a two-hour skills-building workshop on responding to disrespect and discriminatory behavior.

   c. Discussion of community or non-work incidents that impact team cohesion and coping.

B. INTERVENTION PROGRAM:

Wellbeing and Professionalism coaching program: 1:1 coaching program for faculty or staff who may have a stress injury or who wish to (or whose supervisor wishes them to) enhance their well-being or their functioning at work. Referrals for coaching can be self-referral or by supervisor.

Exhibit 1 (continued)

Draft Memorandum: Proposed Clinician Well-Being Program

C. ASSESSMENT:

Evidence-based measures and exercises that address psychological readiness, coping, burnout, satisfaction with life, resilience, and well-being across several domains are tools that can be utilized by Well-being and Peer Support team members to facilitate participants' knowledge about their current functioning.

Recommendations:

Recommendation 1: Establish an office for well-being and peer support.

Office of Well-being and Peer Support coaching team:

- Six to eight part-time trained peer professionals (physicians, nurses, psychologists, social workers, or chaplains) who are trained in coaching and who devote part of their professional time to their coaching role in the health system.
- Additional members will include representation from the Employee Assistance Program (EAP), Clinician Wellness Program, and Compassionate Care Program. Additional team members will include subject matter experts with knowledge and skills related to individual and organizational occupational stress, well-being, and recovery.

Recommendation 2: Complete the development of a stress awareness tool.

Recommendation 3: Begin a system-wide training on stress awareness and peer support using the stress continuum.

Recommendation 4: Create a Well-being collaborative to put together an organized network of well-being activities and resources.

Recommendation 5: Scale the EMR optimization efforts across MVU Health.

Recommendation 6: Scale the team model in primary care to all primary care clinics.

Recommendation 7: Redesign physician compensation to minimize productivity-based weighting.

Total Annual Program Cost: $5 million.

Source: Created by author.