COVID-19: Peer Support and Crisis Communication Strategies to Promote Institutional Resilience

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An infectious disease physician in Milan described his work caring for patients with the novel coronavirus (COVID-19):

> *It is an impossible-to-understand situation, with people intubated in the hall, not enough ventilators, ethical decisions regarding who to intubate, shortage of masks and gloves, confusion and exhaustion. Hell is probably like this. I have no time to understand, to think about and to express emotions.*

Novel coronavirus disease is posing an extraordinary challenge to the health and well-being of persons across the globe. Along with grave threats to social stability, economic prosperity, and human health, caring for patients places great stress on health care workers (HCWs) (1). Because care of the patient depends on providers who are physically and mentally fit, the integrity of the health care system and its capacity to take adequate care of patients are at stake. The authors have had experience responding to severe acute respiratory syndrome (SARS) and H1N1 influenza, formulating a national medical recovery plan in Kuwait, responding to the 9/11 World Trade Center disaster, and developing peer support programs for health care. In this commentary, we summarize lessons learned from those experiences and provide consensus on best practices for fostering an organizational culture of resilience (2–4).

Health care workers caring for patients with contagious, life-threatening illnesses, such as COVID-19, are likely to have anxiety and fear of being infected. In the case of SARS, up to 50% of HCWs had acute psychological distress, burnout, and posttraumatic stress while caring for these patients (1, 5). Fear of contagion and of infecting family members, social isolation, and additional stressors contributed to adverse outcomes (1, 5). The stress of prolonged exposure to COVID-19 and the need to support clinicians have been noted in recent publications (6, 7).

We have observed similar responses to COVID-19 in our HCWs, especially among those with a high risk for exposure to infectious material, such as workers in biocontainment units and emergency departments. Shortages of personal protective equipment may provoke anger, frustration, and helplessness. Nonprofessional staff and those working in less visible parts of the hospital, such as laundry and facilities, receive less information, making them feel isolated and disempowered. Staff also must contend with sometimes daily shifts in policy, fear of contagion, and added work, as well as obligations to family and others outside the hospital. If staff are unsupported, COVID-19–related trauma may cause symptoms of distress and burnout and decrease their ability to function effectively. These symptoms may evolve into posttraumatic stress disorder or other chronic conditions (5). Feeling out of control and unappreciated increases the number of people calling out of work. In the case of SARS, perceived adequacy of preparatory training and support mitigated long-term adverse outcomes (5). This calls for health care organizations to support the mental health of HCWs.

We recommend 3 strategic principles that may be of value for other health care institutions responding to the COVID-19 pandemic: First, provide leadership focused on resilience. Effective crisis management provides a clear, optimistic vision and realistic plan; takes decisive action; and facilitates open, honest, and frequent communication. Leaders should make extra efforts to thank workers and express gratitude for the extra burden being imposed on them.

Second, structure crisis communications to provide information and empowerment. In the absence of information, imagination and worst-case scenarios rush in. Information can help to reduce anxiety. Leadership should provide the most up-to-date information on COVID-19, what is being done to protect HCWs, and what they should do if exposed. Leadership should anticipate questions and answer them in advance. To restore a sense of control, they should empower workers by providing them with information about what they can do to help themselves.

Third, create a continuum of staff support within the organization. Leaders should anticipate a surge of mental health concerns among HCWs at all levels. They should normalize these feelings and encourage their expression, advocate personal wellness, and identify support resources. They should create a peer support team to provide psychological first aid, potentially by tapping into existing employee assistance, chaplaincy, or other wellness programs, with triage when needed to higher levels of support.

At Johns Hopkins Medicine, a unified command center was activated soon after the World Health Organization declared COVID-19 "a public health emergency of international concern." We know that if workers feel they will be supported in a disaster, they will be more resilient; therefore, staff support has been included alongside other essential services, such as infection control and supply chain management.

Johns Hopkins has a confidential peer support program called RISE (Resilience in Stressful Events) (8). RISE responds to calls 24/7 and provides in-person psychological first aid and emotional support to HCWs

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who experience stressful clinical events, such as an unexpected complication or the death of a patient. In the past 5 years, the program has been replicated in more than 30 U.S. hospitals and has helped thousands of workers.

For the COVID-19 response, RISE is coordinating with employee assistance and hospital wellness programs, chaplains, and psychiatrists. Team members round proactively on high-acuity units, while also responding in person to pages from individuals and groups and offering immediate phone support to callers. Attention is given to less visible units, such as the microbiology laboratory, transport, and pharmacy. A useful strategy has been pairing infection control personnel to provide updates with RISE responders to give emotional support. Support efforts will increase if allocation of scarce life-sustaining medical resources becomes necessary. RISE also monitors the command center, where senior leaders and staff work lengthy shifts.

Response to the COVID-19 pandemic is a marathon, not a sprint. Leaders and managers of health care organizations should be forewarned to pace themselves and their responses. When disaster strikes, the emotional response generally occurs in phases (9). Much of the U.S. health care response is still in the early impact and heroic phases. However, planning should begin for a longer, disillusionment phase during which emotional needs among HCWs will grow.

In summary, we describe an approach to enhance the well-being and resilience of HCWs in response to the COVID-19 pandemic. Our recommendations are based on our observations of HCW stress during the SARS outbreak and institutional experience with delivering peer support. This approach has the potential to enhance organizational cohesion and reduce adverse effects for HCWs.

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