Scientific Advisory Group

COVID-19 Scientific Advisory Group Evidence Summary and Recommendations

Managing and Preventing Healthcare Provider Burnout

11 February 2022

The AHS Scientific Advisory Group is a contributing member of COVID-END, the COVID-19 Evidence Network to support Decision-making.

This document summarizes the COVID-END report on Healthcare Provider Burnout and develops key messages and recommendations grounded in the Alberta healthcare system context.

Alberta Health Services

Physical distancing works

Contents

Lay Summary

BACKGROUND

- The COVID-19 pandemic has exacerbated chronic workplace stress and placed extreme pressure on healthcare workers (HCW) and leaders at all levels of AHS. Many healthcare workers are experiencing burnout, which is characterized by feelings of energy depletion or exhaustion, increased mental distance from one's job, feeling negative towards one's career, and a reduced professional productivity
- Many recommendations for HCWs focus on self-care strategies such as yoga, sleep, diet and exercise; however, these do not address the underlying workplace based drivers of burnout.
- Large-scale, organizational strategies for reducing and preventing HCW burnout are required to support healthcare workers and mitigate the emerging burnout crisis
- This document compiles four sources of information: a summary of the COVID-END review on HCW burnout; human resources data from AHS; discussions with stakeholders/secondary reviewers; and additional resources supplied by stakeholders.

KEY MESSAGES

- Burnout is common among health care workers across all health care organizations.
- Many factors contribute to burnout, and effective workplace practices can help reduce or control these factors, which include issues such as: unsustainable workload; perceived lack of control; insufficient rewards for effort; lack of a supportive community; lack of fairness; and mismatched values and skills.
- At times, there is a tension between two pillars of the AHS Quadruple Aim – addressing burnout focuses on the wellbeing and psychologic safety of staff (Our People), but as a healthcare organization AHS has a patient care priority (Patient First) which can put pressure on both direct health care providers and other staff.
- Human resources data from AHS shows a substantial increase in overtime hours, sick time, and disability claims from frontline employees over the course of the pandemic (December 2021, compared to December 2020).
- Strategies for managing HCW burnout at the system level as described in the evidence based reviewed include but are not limited to: focus on creating a positive work environment, improving engagement, collating and streamlining existing resources, optimizing organizational communications, providing opportunity for adequate rest and exercise, and offering supports to help staff cope with usual work stressors, including busy work schedules
- There is a need for a clear governance and accountability structure for any strategy to mitigate HCW burnout, culminating in an executive-level sponsor.
- On stakeholder engagement, a great deal of concern about the potential severe impact of burnout across our people in AHS was noted. Ongoing work was identified within AHS, and by other groups such as Alberta based physician organizations in developing strategies and programs to address burnout. Stakeholders were eager to see this work develop into an actionable strategy. There was significant agreement with the need for a clearly delineated, supported, integrated strategy across all

groups. These recommendations and findings, although presented to AHS, would be relevant to other healthcare related employers.

RECOMMENDATIONS

1. A specific, accountable and resourced group should be responsible for creating, monitoring and overseeing an overarching AHS staff wellness strategy situated in the Our People Foundational Strategy. Designating a single dedicated leader (or dyad) as Wellness Lead(s) should be strongly considered. This high profile role should be an individual(s) within the accountable group who is specifically resourced and supported to oversee integrated and distributed work; can link with all relevant partners; access and refine relevant organizational burnout and wellness metrics to measure impact; and report to the AHS Executive Leadership Team.
2. Leverage the Our People Foundational Strategy to align existing activities and create any needed additional roles, structures or resources to integrate and embed wellness (and burnout mitigation) across the organization. Enhance visibility of the strategy and ensure traceable responsibility and accountability for implementation and assessment of progress reporting structure to high level leadership, with a leadership sponsor or dyad
3. Work with relevant groups outside AHS, including but not limited to Alberta Health, AMA and faculties (eg. Well Doc Alberta, the Physician and Family Support Program (PFSP)), other professional colleges and associations, Homewood Health and others to build a strategy that supports all the healthcare workers in the system.

Authorship and Committee Members

Name	Contribution
Meenakshi Kashyap	Extraction of key messages from COVID-END review
Lynora Saxinger	Content writer and primary scientific reviewer
Sharron Spicer, Mona Sikal, Tony Bennett, Mircea Fagarasau, Steven Clelland, Frank MacMaster, Nick Mitchell, Matthew Murphy, Jane Lemaire, Teresa Brandon, Jodi Ploquin, Shelley Howk, Alicia Polachek, Jennifer Williams	Secondary scientific reviewers – content review and suggestions for revision
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The AHS Scientific Advisory Group is a contributing member of COVID-END, the COVID-19 Evidence Network to support Decision-making. This document summarizes the COVID-END report on Healthcare Provider Burnout on 7th December, 2021, to develop key messages and recommendations grounded in the Alberta healthcare system context.

Topic: Management and Prevention of Healthcare Provider Burnout

Background

- The experience of burnout, a syndrome resulting from chronic workplace stress, among healthcare workers (HCWs) has been a longstanding challenge in health systems that predates the current pandemic and is considered a threat to healthcare workers and to the overarching healthcare systems (West, Dyrbye & Shanafelt, 2018). Burnout is characterized by feelings of energy depletion or exhaustion, increased mental distance from one's job or feeling negative towards one's career, and a reduced professional productivity (World Health Organization, 2019)
- The unique circumstance of the COVID-19 pandemic has created a situation of severe work overload, and has exacerbated the existing occupational distress crisis within healthcare workers. The psychological impacts and long-term implications of pandemic working conditions at all levels of the health system have yet to be fully identified.
- Organizational strategies, including culture changes, are foundational to mitigating the risk of psychological harm to HCW due to occupational distress syndromes such as burnout and moral distress, and/or exacerbation of mental illness. Organizational strategies also improve engagement and organizational resilience.
- The December 2021 Psychological Health and Safety in Canadian Workplaces Survey (Mental Health Research Canada, 2021) reported data relevant to healthcare worker burnout in AHS:
    - Across provinces, Albertans reported a harder time finding work-life balance than residents of other Canadian regions
    - Across occupations/industries, Canadian healthcare workers were more likely to report experiencing burnout, traumas, discrimination, and harassment, and to report being treated unfairly due to mental health concerns than individuals in other workplaces
    - Across all Canadian industries, self-reported burnout was highest among healthcare workers (53%), and of healthcare workers, 66% of nurses surveyed indicated that they felt burnt out
    - Canadian healthcare workers were least likely amongst employees to feel that their employers promote work-life balance or try to prevent burnout

- The experience of burnout during the pandemic may be exacerbated by factors outside of work (such as the societal impact of public health responses that affect personal life, family and personal health, education, and care challenges which can also be an equity challenge that disproportionately affect women and parents of dependent-aged children)
- Physician burnout and other healthcare worker burnout often addressed separately in both some literature and in resources meant to mitigate burnout. In this document, physician-specific elements will be noted as such, but the interrelationship of health care teams means that many mitigating measures should be beneficial to all.
- This document summarizes a COVID-END report that addressed an evidence synthesis request to identify screening methods, interventions, and system level approaches to address burnout in direct patient care providers during the COVID-19 pandemic. The resulting COVID-END synthesis took the form of a scoping review of available research literature on this topic and was limited to COVID-19 related literature and also incorporates selected information provided by the knowledge user, Dr. Lynora Saxinger, and provider partner, Sam Belbin, both of whom have lived experience on the subject matter.
- In addition, this Scientific Advisory Group document collates several sources of information related to managing burnout among AHS healthcare workers in Alberta. It is noted that these findings would also be relevant to non-AHS healthcare and allied health employers although the recommendations are directed to AHS.
    - A summary of the commissioned report from COVID-END
    - Overview of additional references identified by stakeholders that offer useful structural or organizational models that could be leveraged by AHS
    - Compilation of AHS data, providing some indication of the wellbeing of Alberta's health provider workforce, supplied by AHS Human Resources, AHS Workplace Health and Safety, and Medical Affairs
    - A qualitative summary of stakeholder engagement sessions. Stakeholders/Secondary reviewers for this report were identified within AHS Human Resources, Workplace Health and Safety, Provincial Addictions and Mental Health, and the CMO Physician Health, Diversity and Wellness Portfolio. Additional external stakeholders were also identified from the College of Physicians and Surgeons of Alberta (CPSA), Well Doc Alberta, and Physician and Family Support Program, Alberta Medical Association, who provided comments of the draft.
- The information from the COVID-END scoping review is directed toward all stakeholders, including Alberta Health Services, provincial regulators, physician organizations and researchers who are interested in exploring organizational strategies to support the well-being and address burnout in HCWs.

- As a whole, this summary and review document is intended to support AHS leaders in developing a strategy to address burnout in staff across the organization.
- These recommendations and findings, although presented to AHS, would be relevant to other healthcare related employers.

Key Messages from the COVID-END review, additional resources, and Stakeholder Engagement

- The COVID-END scoping review provides a good starting point for identifying pandemic specific tools and organizational interventions to address health care provider burnout; however, the scoping review methodology and focused search (which excluded pre-COVID-19 literature) limits ability to make definitive evidence-based recommendations around optimal organizational burnout strategies which has become abroader question. It also constrained to literature addressing burnout in direct patient care based health care providers but this syndrome affects the entire health care workforce (ie administrative, public health, laboratory, environmental and nutritional services staff and others.)
- Additional stakeholder consultation was conducted (in the form of an extended secondary review period and series of discussions) to contextualize the research findings and identify existing programs, resources and potential barriers within the Alberta healthcare system that will impact the next steps of addressing the HCW burnout crisis
- Additional articles, programs, and resources supplied by reviewers support, extend and confirm the findings of the COVID-END review and are listed in Appendix A. Additional materials around corporate change management strategy were also reviewed.
- Many factors contribute to the development of burnout, each of which can be partially mitigated by an effective organizational strategy, including unsustainable workload; perceived lack of control; insufficient rewards for effort; lack of a supportive community; lack of fairness; and mismatched values and skills.
- Individual-level activities and interventions to build resiliency have a role in helping staff manage their own well-being; these measures may assist with symptoms of burnout but do not address the underlying causes (e.g. overwork and suboptimal workplace conditions, work related moral distress, ongoing work-related trauma).
- Strategies for managing HCW burnout at the system level include but are not limited to a focus on creating a positive work environment, improving engagement, offering clear organizational communications, providing opportunity for adequate rest and exercise, and offering supports to help staff cope with overloaded work schedules. Healthcare organizations can organize their support structures based on the following heuristic device identified in the scoping review**: Hear me, Protect me, Prepare me, Support me, and Care for me** (Shanafelt, Ripp & Trockel, 2020)

- Additional resources identified describe the importance of an accountability structure for an organizational wellness strategy, which for some successful health care organizations has included a formal role of a Chief Wellness Officer, champion or high-level accountable sponsor.
- AHS human resources data and reports from the Workers Compensation Board show a substantial increase in the overtime rate, sick rate, and disability claims from clinically focused employees in December 2021, compared to December 2020. Specifically, stress-related injury claims have increased by 26% over the same period.
- At times, there is a tension between two pillars of the AHS Quadruple Aim – addressing burnout focuses on the wellbeing and psychologic safety of of staff (Our People), but as a healthcare organization, AHS has a patient care priority (Patient First) which can put additional pressure on both direct health care providers and other staff.
- AHS Psychological Health and Safety Steering Committee has collated a list of resilience, wellness, and mental health resources that are available to all AHS staff to support individual resilience
- There is ongoing work within AHS and Alberta physician organizations to develop strategies to support all healthcare workers that may be integrated and leveraged.
- The stakeholder engagement conducted for this review confirmed that healthcare worker burnout is a pressing concern across AHS, and that an organization-wide strategy should be developed alongside individual tactics, including individual self-care or unit-level initiatives.

Committee Discussion

The committee supported the spirit of the recommendations presented, with the discussion focusing on refining the framing and scope of the recommendations and practical guidance. It should be noted that the recommendations presented are evidence-informed but incorporate a considerable amount of expert opinion to ensure that they are reasonable and actionable.

The Psychological Health and Safety Steering Committee (PHSSC) was confirmed as a pivotal group in this work, although concerns were raised that the current name of this committee implies that all burnout is psychological in nature. The co-chairs of the PHSSC described their existing accountability and linkages between AHS groups (eg. Human Resources; Workplace Health and Safety; Medical Affairs; and Equity, Diversity & Inclusion) and physician groups. It was suggested that a burnout mitigation/wellness dedicated subgroup might consider a different name and ensure broader representation and scope.

There was some debate about the best governance and accountability structures for an organizing body for this work. Some reviewers suggested that a burnout management strategy should use a distributed accountability model (analogous to Equity, Diversity and Inclusion work or workplace safety strategies), while others felt strongly that a more specific supported role in addition to distributed and integrated work better reflected the

principles and models identified. This role (Chief Wellness Officer or champion) would see an individual with dedicated time and resources to develop, coordinate, and oversee distributed activities, who reports to senior leadership on behalf of the strategy team. It was identified that a wholly new strategy would offer be less likely to offer sustained organizational change, so designing and implementing a strategy under the Our People Pillar, with iterative pilots, program adjustment and monitoring should be considered. The committee agreed that a continuous quality improvement approach with metrics and reporting (possibly via the Our People quarterly reports) would be a useful way forward.

Recommendations

1. A specific, accountable and resourced group should be responsible for creating, monitoring and overseeing an overarching AHS staff wellness strategy situated in the Our People pillar of the AHS Foundational Strategies. Designating a single dedicated leader (or dyad) as Wellness Lead(s) should be strongly considered. This high profile role should be an individual(s) within the accountable group who is specifically resourced and supported to oversee integrated and distributed work, link with all relevant partners, access and refine relevant organizational burnout and wellness metrics to measure impact, and report to the AHS Executive Leadership Team.
   Rationale: Many successful reported strategies identify the importance of a designated leadership position (sometimes called a "Chief Wellness Officer") in strategy deployment with high-level support and reporting. It is identified that the current Psychological Health and Safety Committee is well positioned with expertise in this arena, but additional resources and linkages may improve the ability of the group to gain momentum and enhance visibility. This strategy should be prepared in collaboration with the CMO Wellness, Diversity and Leadership Development Portfolio, as some of the strategies could be considered within the plan to roll out Trauma Informed Leadership in 2022.

2. Leverage the Our People Wellness Strategy to align existing activities and create any needed additional roles, structures or resources to integrate and embed wellness (and burnout mitigation) across the organization. Enhance visibility of the strategy and ensure traceable responsibility and accountability for implementation and assessment of progress reporting structure to high-level leadership, with a leadership sponsor or dyad.

3. Liaise with relevant groups outside AHS, including but not limited to Alberta Health, AMA and faculties (eg. Well Doc Alberta, the Physician and Family Support Program (PFSP)), colleges and professional associations, Homewood Health and others to build a wrap-around burnout mitigation strategy that supports all the healthcare workers in the system.
   Rationale: Hospital-based care providers are not the only staff who require support. Lab staff, phlebotomists, the public health workforce, and leaders have also been experiencing the heavy workloads and external pressures that can lead to burnout. Many of these connections already exist due to the work of the PHSSC.

Practical Guidance: initial actions

In addition to elevating importance of an overall strategy as described above, the COVID-END review and subsequent discussion noted a number of actions and considerations that offer potential to mitigate staff and physician burnout in the current pandemic phase.

1. Identify the key groups in the current structure (such as the current Psychological Health and Safety Steering Committee) to initiate immediate actions around the underlying drivers of staff burnout concurrently with strategy development (expanding their scope and appointing sub-committees or working groups as necessary):

    - Further assess the evidence around effective priority organizational strategies for staff and physician wellness and burnout mitigation, and further delineating the key resources required, potentially including the commissioning of a dedicated review of pre-COVID-19 literature on organizational and systemic wellness strategies if needed.
    - Identify a suite of tools and activities, which can be implemented in the short to medium term to help mitigate the drivers of burnout (eg. creating an easily accessible Insite and external page for wellness resources; framing communications to specifically recognize the challenges facing staff; launching facilitated engagement sessions and peer-to-peer support programs) in the context of an overall developing strategy
    - Ensure integration of resources and approaches to physician wellness as part of a single health workforce strategy, recognizing that most physicians working in AHS are independent contractors who may have needs and concerns that are unique from those of AHS staff. There are some unique supports available to physicians through physician organizations that should be aligned and considered (e.g. AMA PFSP for assessment and support and Well Doc Alberta in partnership between the AHS CMO Wellness, Diversity and Leadership Development Portfolio, Well Doc Alberta, PFSP and CPSA. Additional resources for other health care provider groups should be integrated and considered as identified.

2. Potential priorities identified for short-term action within this review include but are not limited to:

    - Create a specific, easily accessible home with links to existing resources for clinical staff and non-clinical staff on Insite. The work to collate resources within AHS has already been completed by the Psychological Health and Safety Steering Committee and resources tailored to physicians are available from AHS, Well Doc Alberta (Support Services and Education Sessions), the Canadian Medical Protective Association, Canadian Medical Association and through academic institutions.

- Launch a specific campaign, using appropriate facilitation, to invite engagement during the development of an organizational burnout strategy. These may include a feedback portal, town halls, and /or other outreach using relatable narratives and examples (“Hear Me”), coupled with sharing psychological support resources (“Support me”). The “COVI’D like to chat” initiative is a model that could be expanded to include different staff groups.
- Refocus organizational communications around the Quadruple Aim to ensure the explicit documentation of considerations around healthcare provider experience and well-being into organizational operations and strategic planning. Healthcare professional well-being should be explicitly viewed as a principal responsibility of system leaders (Shanafelt et al., 2020).
- Identify core metrics that should be measured on an ongoing basis to inform assessment of the overall severity and impact of burnout in AHS and allow iterative assessment as strategies to mitigate burnout are implemented. This may include development of new metrics as part of ongoing surveys (validated questions on burnout, open-text / qualitative feedback) and may be done at an individual level or unit level as appropriate. This could also be used to assess units, hospitals, areas where burnout is most common, allowing prioritization of resources and effort where it is most needed.
- Identify and share scalable existing resources, programs, priority pilots based on the Our People working group review (with implementation support) that could be leveraged more broadly across the organization (e.g. peer support and coaching initiatives)
- Given the unique needs of physicians, further work on the resources and strategies that would be most effective for mitigating burnout in physicians should also be undertaken, in partnership between the AHS CMO Wellness, Diversity and Leadership Development Portfolio, Well Doc Alberta, PFSP and CPSA.

Research Gaps

- There is a need to refine applicable metrics of burnout in healthcare organizations, to allow iterative, outcomes based assessment of piloted interventions
- The evidence behind specific organizational strategies to manage burnout (as opposed to individual self-care strategies) is relatively new and is largely based on the published experiences of single organizations or expert opinion.
- There was limited in-depth analysis of the effectiveness, feasibility or appropriateness of the identified interventions in the COVID-END review. Further work is needed to determine the feasibility, applicability and priority of the interventions identified in the scoping review.
- There is little outcomes based evidence defining optimal interventions for organizational culture change around burnout

Evidence Summary and Local Context

Section 1. Summary of the COVID-END review

Burnout is defined as a syndrome resulting from chronic workplace stress that has not been successfully managed. In this rapid COVID-END scoping review, eighty reviews and studies of varied methods and study quality were identified. Studies specifically addressing interventions related to burnout in healthcare workers (HCWs) were empirically based, whereas reports and discussion papers discussed system level approaches related to burnout.

Question 1– What approaches to screening have been reported to identify those direct patient care providers experiencing or at risk of burnout related to COVID-19? How can the screening approaches be used to prioritize services for those direct patient care providers experiencing or at risk of burnout related to COVID-19 [and other workplace contextual factors].

Twenty five articles addressed screening for burnout:

- The Maslach Burnout Inventory (MBI) was the most frequently used tool, cited in 21 of the 25 studies included in the review. Other tools were identified, but no tools were validated for screening for burnout in healthcare workers at an organizational level.

Five reviews on screening indicated that all HCWs are at risk for burnout regardless of profession, gender, age, and years of experience or type of healthcare provided. One factor of particular interest emerging from the literature is that stigma related to COVID-19 in the earlier part of the pandemic was a potential factor in burnout.

It is noted that the COVID-END review did not include unit/workplace level screening specifically, but that organization wide an ecologic rather than individual approach may assist in identifying areas where the organization might target workplace focused mitigation strategies.

Question 2 – What interventions/programs have been reported to assist and/or support those direct patient care providers with burnout or at risk for burnout related to COVID-19?

The synthesis identified nine articles that reported a wide range of intervention strategies:

- Interventions targeting individuals typically included those with a self-care focus such as mindfulness training, cognitive behavioural therapy, and exercise (with a particular focus on low-intensity activities such as yoga or Qigong). Interventions at the system level focused on generating a positive work environment – such as ensuring favourable work conditions, improving engagement, offering clear

organizational communications (such as clinical guidelines, best practices, and policies), providing opportunity for adequate rest and exercise.

Question 3 – What system level approaches have been reported to support positive culture change related to delivery of healthcare in the context of COVID-19?

Fifty-five articles (20 systematic reviews and 35 primary studies or reports) on this topic provided the following information:

- System level change-oriented recommendations highlighted flattening the hierarchy to encourage communication and collaboration between all levels in the organization, reducing workplace stress through cognitive unloading (automating and delegating tasks), and improving organizational agility. Examples of strategies in the literature include psychological PPE, pairing staff to monitor/check on distress levels, and creation other workplace supports – such as listening to and responding to the concerns of the HCWs, assisting HCWs cope with overloaded work schedules by providing amenities such as free parking, available food to purchase, and quiet rooms for time out periods.

AHS reviewers noted that measures of burnout and professional fulfillment (eg. Stanford PFI, Mini-Z, work-life integrations scales, and measurements of groups rather than individuals) may be more likely to provide actionable results, as we develop strategies to do longitudinal assessment.

Research Gaps and limitations of the COVID-END scoping review

The research question for the scoping review was limited to burnout in direct patient care providers or HCWs, which limits the information that could potentially be gathered from individuals in other professions who also are at significant risk of burnout. While the literature highlighted the importance of measuring and monitoring burnout in HCWs none of the included studies described the results of applying a screening tool, such as the MBI, within an institution or system. As a result, there is paucity of information on how results from screening for burnout are utilized to develop interventional strategies.

The search period for the review was limited to from January 2020 up until September 7, 2021. Further, while scoping reviews are able to provide an overview of the available literature, they are not an in-depth examination of effectiveness and thus cannot answer questions about the impact of each of these interventions on outcomes of interest, including wellness and the incidence of health care worker burnout, and thus definitive recommendations are not possible.

Section 2: Findings from Additional Resources

A number of additional resources were identified by secondary reviewers or in additional targeted searches as examples of structural or organizational responses to widespread staff burnout. They are included in Appendix A and the content was used to develop the

practical guidance in this document. Three of these additional resources are highlighted here.

The article "Beyond Burned Out" in the Harvard Business Review (Moss, 2021), highlights that burnout is not just an employee problem that can be solved with self-care, but an organizational problem that is characterized by six key factors: **unsustainable workload; perceived lack of control; insufficient rewards for effort; lack of a supportive community; lack of fairness; and mismatched values and skills**. A large-scale survey showed that burnout was a globally prevalent problem that had only accelerated due to the pandemic (Moss, 2021). Opportunities to support workers as the pandemic continued were either missed (such as offering flexibility with childcare arrangements or emphasizing regular work hours) or withdrawn (such as cancelling "hero pay") (Moss, 2021). Moss (2021) suggests that organizations can support burned out employees by helping managers mitigate workload, promoting mental wellness and reducing the stigma of mental health discussions, assisting managers with developing empathy and listening skills, and prioritizing activities that help employees develop meaningful connections with each other and with family and friends.

Second, the articles by Shanafelt et al. (2020) and Brower et al. (2021) offered useful strategies for organizations to build and coordinate a large-scale initiative to manage employee burnout. These include appointing a Chief Wellness Officer whose role to measure employee well-being and champion interventions to mitigate burnout (Brower et al., 2021) and building foundational programs to support clinicians in distress, promote community across the organization, prioritize the wellbeing of staff in all decisions, and build a culture of engagement to assess wellbeing on an ongoing basis (Shanafelt et al., 2020). These factors are summarized in a framework that highlights five fundamental requests from healthcare professionals: **Hear me, Protect me, Prepare me, Support me, and Care for me** (Shanafelt, Ripp & Trockel, 2020). This heuristic device was identified in the COVID-END review and describes the overall needs of HCWs who manage the stress of working during the pandemic:

- Hear me: respondents wanted the hospital to demonstrate that healthcare workers' views were respected.
- Protect me: requests for protection from COVID-19 (PPE, increased staff testing, allowances for remote work)
- Prepare me: operational realities (new work needed, like COVID-19 screening, surge capacity planning) generated some unpredictability in hospital staffing needs, resulting in palpable anxiety among healthcare workers about when and to where they might be redeployed.
- Support me: for extreme workloads, family/personal needs, and mental health concerns; leadership visibility in the workplace (or lack thereof) influenced healthcare workers' perceptions of being supported.
- Care for me: comments revealed the positive impact of having leaders who showed compassion and appreciation for healthcare workers

The Shanafelt et al. (2020) report on organizational strategies for HCW well-being lists the dimensions of several foundational programs that are effective and evidence-based. These are:

- Safety-net resources for clinicians in distress
- Resources to address the needs of individuals during major life transitions
- An appropriate array of evidence-based self-care and wellness promotion offerings
- Deliberate programs to promote collegiality and community at work
- Assessment of well-being and its driver dimensions at recurring intervals coupled with a robust approach to disseminate results to clinical and operational leaders
- System-wide approaches that provide clinicians the opportunity to identify and prioritize the local factors that irritate them ("pebbles in the shoe") and a process that empowers them to address these

These two summary frameworks are complementary and both support a wraparound strategy that addresses different levels of the healthcare system and different drivers of burnout.

Section 3: AHS Context, Data and Preliminary Stakeholder Engagement

As the evidence in the scoping review was insufficient for evidence-based recommendations, the process of review and contextualization for AHS was adapted to allow for additional stakeholder consultation (as additional secondary reviewers) through meetings, focus group discussions, and written comments to develop guidance.

Current data on healthcare worker burnout indicators in AHS

Human resources data from AHS shows a substantial increase in the overtime rate, sick rate, and a significant increase in disability claims from clinically focused employees between December 2020 and December 2021 (Figure 1).

- The overtime rate (overtime hours as a percent of paid hours) for clinically focused employees increased from 2.8% in December 2020 to 3.4% in December 2021 – an increase of 45,000 overtime hours
- The sick rate (sick hours as a percent of paid hours) for clinically focused employees increased from 6.1% in December 2020 to 6.4% in December 2021 – an increase of 22,000 overtime hours

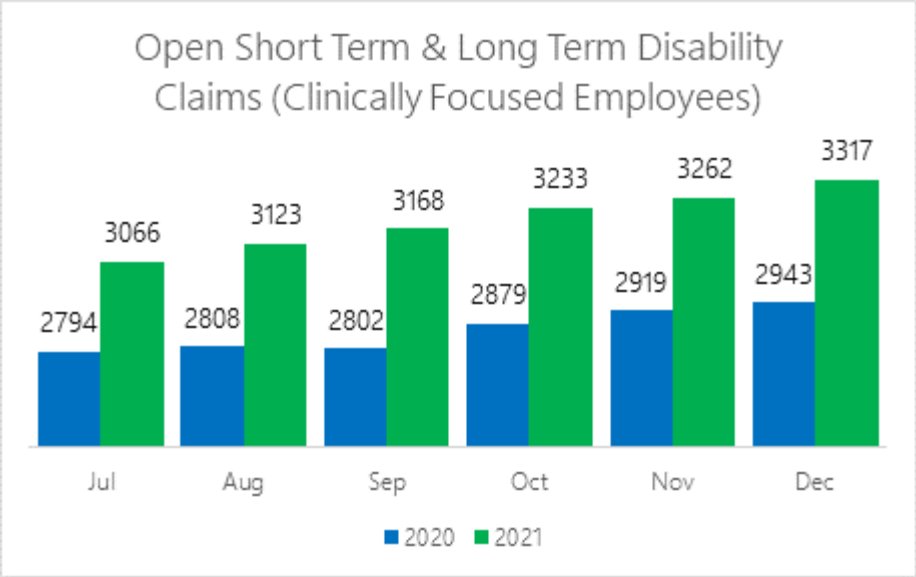

Figure 1. Difference in disability claims among clinically focused employees between 2020 and 2021.

Reports from the Workers Compensation Board of disabling injuries (defined as an injury resulting in an employee missing work hours beyond the remainder of the shift in which the injury is sustained) show that Psychological and Psychological Trauma injuries in the second quarter of 2021-2022 (encompassing stress and anxiety) contributed for 10.8% of total disabling injuries. This is an increase of 26.4% over the same quarter from the previous year. Psychological injury and trauma make up the third highest injury category within AHS.

Summary of engagement with stakeholders

An extended stakeholder engagement / secondary review process was undertaken for this review. Secondary reviewers for this report were identified within AHS Human Resources, Workplace Health and Safety, Provincial Addictions and Mental Health, and the CMO Diversity and Wellness Portfolio. Additional external stakeholders were also identified from the CPSA and Well Doc Alberta.

Every individual contacted for this review saw HCW burnout as a major priority and were concerned about the health and wellbeing of patient care providers, employees across all levels of AHS, and health care leaders due to the prolonged pandemic response.

In addition to highlighting the need to design an approach based on pre-pandemic principles (as identified in the additional resources), consideration of the possibility of specific post-pandemic needs was highlighted:– i.e., disability related to healthcare workers with long COVID syndrome; exacerbated mental illness during the pandemic. The need to directly address moral distress with debriefs by trained professionals and compassionate communications from leaders was noted, to create a shared understanding that that everyone is tired and the return to normal will take time, and that

there could be some medium to long term psychological distress related to the pandemic.

Stakeholders identified ongoing activities, programs, and resources that support an organizational response; they also noted several barriers that will need to be mitigated for an organizational response to be effective. These are listed in Table 2 below.

Table 2. Enablers, Resources, and Barriers that currently exist in AHS.

Enablers and Resources	Barriers
• Addressing AHS staff and physician burnout is a high priority for AHS leadership • The AHS 'Our People' Strategy leverages the Provider Experience element of the Quadruple Aim • Homewood Health Employee and Family Assistance Program & Headversity App • Investment in self-driven mental health care options for all Albertans, such as Togetherall, Psychological First Aid training, and HeartMath. • Mental Health & Resilience Resource Guide (maintained by HR) • Organizational initiatives for scaling & spreading peer-support networks, crisis management teams, listening hubs • Active work and support on burnout from HR, Workplace Health and Safety, and Medical Affairs • Expanding mental health care capacity to ease strain on under-resourced areas (Provincial Addictions and Mental Health) • Communications data to build approaches that will work • Well Doc Alberta, an Alberta resources for physicians which offers support for developing, training and launching Peer support teams for groups of Physicians	• Burnout is a widespread challenge in the organization and is experienced by patient care providers, leaders, and everyone in between • The extreme healthcare pressure created by the pandemic is in excess of any previously anticipated challenge, and exceeds surge capacity of current health infrastructure and staffing • The experience of burnout during the pandemic may be exacerbated by factors outside of work (such as the societal impact of public health responses that affect personal life, family and personal health, education, and care challenges which can also be an equity challenge that disproportionately affect women, parents of dependent-aged children) • Cultural barriers (stigma and shame) may affect likelihood of accessing help for burnout • Currently there is felt to be a low likelihood and capacity of engagement in surveys and impersonal methods of engagement, new top down initiatives, or prototypical initiatives that are rooted in self-care and resilience as self-care practices may not be feasible during periods of extreme healthcare stress • Conflict regarding contractual arrangements for staff and physicians leading to additional stress

Qualitative summary of comments from stakeholder engagement activities

The sustainability of staffing (in the short and long term), and concerns regarding people leaving healthcare-based careers permanently as a result of the pandemic experience were common in discussions, and all reviewers made comments about the magnitude of the burnout crisis facing Alberta.

> "As we emerge from the acute care crisis, HCW burnout will be the next crisis."
>
> - Stakeholder comment from engagement activities

Moral distress was an identified concern among both AHS staff and physicians. Examples within AHS hospitals were offered, such as unit-level managers concerned about the wellbeing of employees experiencing or at risk of burnout, but are required to schedule coverage to ensure a minimum degree of patient safety regardless of these concerns. Staff within AHS (as within all health organizations) don't know if they will have a charge nurse, have had holidays cancelled, are pressured to do overtime work, and at other organizational levels are attending meetings and working on weekends, evenings and holidays.

There was broad agreement that standard pre-pandemic, self-care based "resilience" initiatives (e.g. yoga, diet, exercise, sleep) would not be a priority focus on its own, beyond providing access to potential resources for staff and physicians in a centralized way. Stakeholders recognized the role that AHS, as an organization, must play in managing staff burnout and supported leveraging existing programs and resources rather than building something new.

There was concern that front line staff may not realize that their burdens and stresses are being seen, are acknowledged to be excessive during pandemic pressures, and are important to their leadership. One stakeholder described the tension between two key pillars of the Quadruple Aim – prioritizing the emotional and psychological safety of Our People may seem to be in conflict with AHS's Patient First priority as a healthcare organization. Engagement with staff to communicate, listen, and offer ways to provide input into developing mental health and wellbeing supports was seen as a priority.

The need for more data on burnout was discussed. All stakeholders recognized the limited appetite for surveys and other impersonal methods of engagement. While baseline data may be useful, such as that collected in ongoing Gallup polls, this was considered most useful in the context of developing an institutional system of iterative assessment of burnout and response to interventions in a quality improvement framework (Shanafelt et al., 2020).

Initial priorities included staff engagement and communications strategies. Suggestions included:

- Develop communications with relatable narratives about the impact of current pressures,
- Create a centralized AHS web presence under Our People –Wellness Resources and Burnout Assistance
- Consider the creation of a “listening” interface/platform where staff input can be facilitated and collated as a specific burnout-wellness strategy is developed.

It was broadly acknowledged that there is a need to elevate the Our People Foundational Strategy as a priority across AHS communications / platforms / strategies so that comments on sustainability of operational plans and staff support become the norm. It was suggested that the Our People Strategy be used rather than a newly named burnout or wellness strategy or group, and existing groups such as the Psychological Health and Safety Steering Committee can lead the governance of this work (eg. identifying the responsible, accountable groups, the consulting groups, and informed groups).

Resources from within AHS were highlighted: several groups across AHS and external groups are involved in potentially scalable resources and programs. Developing a complete inventory of current resources and dedicated Insite page with resources should be a priority (currently, searching “burnout” does not lead to a curated resource collection.)

The application of evidence from COVID-END review in health care delivery settings was also discussed in the stakeholder focus groups:

1. Care Units

   Potentially implementable strategies at care units were identified in the evidence review, but challenges in adding workload (new programs, checklists or the like) and in

Examples of strategies for managing organizational burnout

- Improving workflow management – tasks transformed (eg. prewritten prescriptions, central preparation of medications)
- Organizing services with an emphasis on reducing workload
- Arranging discussion meetings
- Increasing interoperability to improve organizational agility by reallocating duties
- Providing the opportunity for having adequate rest and exercise
- Holding workshops on coping skills
- Local workforce support desk (access to services, accommodation, transport, other supports)
- Decreasing the clinical demand via schedule changes
- Providing clear and up-to-date guidelines and protocols for different situations

engaging the appropriate people in teams as champions of some of these strategies were acknowledged.

Practically, it was suggested that care unit managers need to be engaged by asking the question, “How do we get help in front of you and how do we make it happen? What do you need?”. Communications strategies to reach frontline staff, outside of email, are likely required (eg. posters in bathrooms, table cards with resources by QR code).

2. System strategies:

Specific system strategies were not identified in the COVID-END review but thematically, the ideas of improved communication, “flattening the hierarchy”, and workplace-based psychological health strategies were identified as protective. It was noted that peer support is a major mitigating factor against burnout so a peer support framework and resources should be designed to reach the local team level.

Taken together, the stakeholder engagement sessions conducted for this review confirmed that healthcare worker burnout is a pressing concern across the organization. It must be addressed with large-scale, organizational strategies in addition to individual self-care or unit-level initiatives.

Appendix A. Links to resources supplied by primary and secondary reviewers

- Beyond Burned Out (Moss, 2021)
- A blueprint for organizational strategies to promote the well-being of health care professionals (Shanafelt et al., 2020)
- The Evolving Role of the Chief Wellness Officer in the Management of Crises by Health Care Systems: Lessons from the COVID-19 Pandemic (Brower et al., 2021)
- Mental health of Health Care Workers (HCWs): a review of organizational interventions put in place by local institutions to cope with new psychosocial challenges resulting from COVID-19 (Buselli et al., 2021)
- WellMD Centre (Stanford University)
- Center for Stress, Resilience and Growth (ICAHN School of Medicine at Mount Sinai)
- Joy In Work Resource and Conversation Guide (Institute for Healthcare Improvement)
- Pyschological PPE resources (Institute for Healthcare Improvement)
- Cumming School of Medicine (University of Calgary) COVID-19 Physician Wellness Resource
- Faculty of Medicine and Dentistry (University of Alberta) Chief Wellness Officer
- A systematic review of organizational strategies to mitigate the psychological impacts of COVID-19 on frontline staff is underway by a research group at McMaster University (PROSPERO registration CRD42020203810)

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