Needs Assessment Framework

Introduction

Program: "Caring for Those Who Care for Us" - A Mind-Body Pilot Program Addressing the Crisis in Health Care Worker Stress and Burnout

Target Population/Participants: The full range of clinical and nonclinical hospital healthcare workers.

The Health Issue: A History of Healthcare Worker Stress and Burnout

As outlined in the program Impact Statement, stress, and what we've come to know and now freely refer to as "burnout", has been around for decades, and is only getting worse. Is it a by-product of modern life? Perhaps. In any case, it's been fifty years since German-born, American clinical psychologist, Herbert Freudenberger first used the word "to describe the physical and emotional exhaustion experienced by frontline healthcare workers which result from the prolonged, excessive demands in their workplace (Freudenberger, 1974)".

The symptoms and costs to workers, families, healthcare organizations, and communities are well-known and well documented. Unsurprisingly, as a workplace issue, "burnout" it's not confined only to medical professionals; it afflicts clinical and nonclinical healthcare workers alike. Everyone from physicians, nurses, technicians, and medical assistants, to office, food service, housekeeping/janitorial, and patient transport workers (Zerden et al, 2022) is impacted. Countless studies have shown that secondary traumatic stress (STS) and burnout negatively impact workforce efficiency, patient care, and patient satisfaction, increases medical errors, absenteeism, and job turnover, and contributes to the already dire shortage of healthcare workers (Felton, 1998). Its severity has only grown, with U.S. physician burnout reaching an all-time high of 63% during the COVID-19 pandemic.

The 2017 study, "Burnout Research: Emergence and Scientific Investigation of a Contested Diagnosis" consisted of "…an extensive quantitative and qualitative literature analysis on all [1,225] publications on burnout listed in *PubMed*" (Heinemann & Heinemann, 2017) by year, from 1978 until 2011. The graph showed a stunning 3-fold increase in publication volume since 2000.

In May 2022, the Office of the U.S. Surgeon General published an Advisory called "Addressing Health Worker Burnout" and defines "…health workers broadly as all the people engaged in work to protect and improve the health of individuals, communities, and populations, including those who assist in operating health care facilities." It "…cites high rates of burnout and mental health challenges such as stress, anxiety and depression among both clinical and non-clinical health workers (e.g. operations staff in health facilities and public health workers)". (Murthy, 2022)

Even pre-pandemic, the advisory cites the National Academy of Medicine report that burnout among U.S. healthcare workers had reached "crisis levels", with 35-54% of physicians and nurses reporting symptoms (Murthy, 2022). An October 2020 study that found 49% of health workers, including nursing assistants, medical assistants, social workers, and housekeepers, reported burnout and 38% reported symptoms of anxiety or depression.

Below is additional data from three research studies of more than 1,100 healthcare workers conducted from June through September 2020, cited in the Surgeon General's Advisory:

- 93% reported they were experiencing stress
- 86% reported anxiety and
- 76% reported exhaustion and burnout

(Murthy, 2022)

Healthcare worker stress and burnout has reached such a crisis level that immediate and bold action must be taken to ensure healthcare organizations can attract, train, and maintain a healthy, compassionate, and competent healthcare workforce. For far too long America has failed to adequately value and support healthcare workers. The pandemic only deepened the crisis and shed a much-needed spotlight on it. Effective tools and solutions exist in the form of integrative health practices such as mindfulness meditation, Qigong, and auricular acupuncture/acupressure. All three mind-body practices are cost-effective, accessible to all hospital workers in the hospital setting, easy to learn, and have been the subject of encouraging evidence-based research.

In his introduction to the Advisory, Surgeon General Murthy says, "As we transition towards recovery [from the pandemic], we have a moral obligation to address the long-standing crisis of burnout, exhaustion, and moral distress across the health community. We owe health workers far more than our gratitude. We owe them an urgent debt of action." (Murthy, 2022)

Costs of Healthcare Worker Stress and Burnout:

Negative consequences of this health issue include:

- decreased quality-of-life, physical and mental health, and increased compassion fatigue--insomnia, heart disease, diabetes, isolation, substance abuse, anxiety, depression, interpersonal challenges, and emotional exhaustion for workers.
- patients have less time with health workers, delays in care and diagnosis, lower quality of care, and medical errors for patients.
- workforce shortages, retention challenges, limited services, risk of malpractice, decreased patient satisfaction, and increased costs for healthcare systems.
- erosion of trust, worsening health outcomes, increased health disparities, lack of preparedness for public health crises for community and society. (Murthy, 2022)

Program Benefits:

- Empowers worker resilience, increases job satisfaction, and improves overall quality of life
- Normalizes self-care as a daily practice
- Strengthens teamwork and camaraderie
- Reduces medical errors and costs and improves community relations
- Hospital demonstrates its appreciation for workers
- Reduces absenteeism and increases worker retention
- The opportunity to become a leader in hospital management and a model for supporting workers

Objectives, Strategies, and Desired Outcomes

As the first step towards describing and understanding a metropolitan hospital's current state of worker stress, emotional exhaustion, and burnout, the wellness team will seek both quantitative and qualitative data for the needs assessment, beginning with the CDC Worksite Health ScoreCard, a quantitative measure which represents an easier and less costly route than developing and administering a new survey.

Data and Data Collection Methods:

On the qualitative side, data collection will occur on an interpersonal basis, and involve face-to-face interviews with hospital leadership, so-called "key informants". The purpose is to discuss the health issue of workplace stress and burnout, its human toll, along with its financial, tangible, and intangible costs, articulate the vision and goals of the proposed program and solicit the leadership teams' observations, concerns, and interest in addressing the problem. The intention is to confirm their "buy-in" and willingness to explore, launch, and sustain an integrative wellness program. An interview questionnaire-script will be developed to guide the conversation and responses will be recorded. Questions will focus on the main causes and consequences of stress and burnout, whether different groups of individuals are affected differently, and if so, why.

Next, hospital leadership will authorize the collection of existing, quantitative data on the full range of hospital employees, gathered from the Human Resources Dept., as well as a search for other useful data that might exist from state and local government agencies, OSHA, and the American Hospital Association. Using the CDC Worksite Health ScoreCard, this secondary data would include race/ethnicity, gender, socio-economic status, education level, absenteeism, participation in employee assistance programs, and perhaps data on travel time to work, health status according to health records and health insurance provider data, (HRA) health risk assessment, and biometric screening, specifically blood pressure, which can be an indicator of stress.

The wellness team will determine how best to organize focus groups—by job description, gender, race, socio-economic indicators, etc., so people are comfortable coming together to discuss their perceptions and how open they are to the proposed program of interventions. Any existing data on specific workers' views of current workplace health programs, interventions, and services, will help shape the focus groups. The team will examine the hospital's CDC Worksite Health ScoreCards over the past few years, especially data on physical activity, stress management, depression, high blood pressure, sleep, and fatigue.

An advisory committee comprised of members of leadership as well as stakeholders representing the full gamut of hospital workers will be created to guide the process from conception through implementation and evaluation. This committee will have input on focus group creation so individuals can express their views and experiences. This data is intended to inform and shape the program design and to gather more qualitative data.

If the CDC Worksite Health ScoreCards are deemed insufficient, a broad survey of all employees will be considered to determine workers' awareness of workplace stress and burnout, its impact on them and their families, and their awareness, interest, and openness to the 3 proposed mind-body self-care practices. A high quality, culturally competent survey will be created, tailored to the divergent target populations, incorporating the right content, and using the most effective method(s) to administer it. The goal will be to select a representative sample of individuals and ask about their health perceptions, behaviors, and needs. The hope is that this costly, labor-intensive, and time-consuming step would not be necessary.

Data Analysis and Use:

These "key informant" interviews will serve to discuss and define the health issue, introduce the program, secure leaderships' "buy-in", identify their role as participants in the advisory group, and engage human resources personnel. HR will work with the program supervisor and staff to collect and provide secondary demographic data. This data will be the basis for gathering primary data from focus groups, developing appropriate questions to be used, and for a general survey questionnaire, if needed. On an individual level how the target population regards its need for stress reduction will be measured. Secondary data will provide insights into the how the hospital can meet those needs. The effectiveness of any programs or support services the hospital is already providing workers will also be measured.

The primary data collected from these activities will be gathered into a report and shared with the program advisory committee. The final needs assessment report will outline the findings and summarize the aforementioned data collection in simple language that all participants can understand, taking into account health equity and social justice.