

Wellness Programs to Promote Resiliency and Health during the COVID-19 Pandemic:

A Rapid Review of the Evidence

Clinical Question: *What is the quantity, quality, and consistency of the evidence for Wellness Programs specific to healthcare clinicians and healthcare workers during the 2020 COVID-19 pandemic?*

Background: The COVID-19 pandemic is the most significant global crisis of the 21st century.^{5,6} While its full healthcare impact is yet to be understood, patterns are beginning to emerge that resemble wartime battlefield conditions.^{1,2} Extreme levels of stress,^{1,2,5} heavy workloads,⁵ exposure fears,^{1,5} and physical exhaustion¹ are leading to mental health symptoms,¹ burnout,¹ and ethical dilemmas.⁵ The healthcare petri dish has rapidly become unpredictable, unstable, and unfamiliar to professional clinicians.^{1,2,5} Healthcare workers' (HCW) physical and mental health must be protected while they focus on the primary mission of patient care.² With this in mind, health organizations have developed a variety of wellness programs to support the mental health of clinicians.^{5,6} A rapid literature review was requested to examine the evidence for wellness programs specific to healthcare clinicians and HCW during the 2020 COVID-19 pandemic. This evidence review is focused on implemented wellness programs and does not include risk factors, characteristics, demographics, or screening related to physical, stress, or mental responses to COVID-19 in the healthcare setting.

Search Results: The COVID-19 knowledge base is approximately 8 months old. Although there is evidence suggesting a need for wellness programs, currently there is little empirical evidence regarding the *effectiveness of implemented wellness programs* for frontline clinician/HCW mental health.^{1,2} A total of 6 citations were found pertaining to operationalized wellness programs.¹⁻⁶ The evidence consisted of expert opinion/commentary,^{3,4,5} performance improvement,² and best practices.^{1,6} Although each citation was ranked from low to high, the final appraisal grade for the quality of this early evidence was deemed low due to the lack of rigorous research studies (See Page 7).

Conclusions/Key Summary of the Evidence:

The evidence was consistent regarding the major concepts, needs, supports, and structure/process/outcome components of wellness programs to

promote HCWs' resiliency and health during the COVID-19 pandemic.¹⁻⁶ Several common themes resonated within these programs, seen in the table above. The overarching outcome goal for all programs was to build and enhance the capacity for workforce resilience and mental health.¹⁻⁶ Table 1 (Page 3) displays the structures and processes various institutions used in program design. While these programs can be distilled into a playbook, executive leadership is needed to breathe life into the program itself.^{1,2,4-6} However, one leader cannot actualize the program alone – it takes a team.^{1,2,3-6}

An Executive Leadership Champion is critical in overseeing a multidisciplinary wellness task force/team^{1,2,4-6} (Table 1, Page 3). This interprofessional group is charged with the oversight/design of multiple strategies offered to HCW within a systems approach framework^{1,5} (See article figures^{2,4}). Executive and local leadership must be visible⁵ and must listen⁵ in order to operationalize the core team and address frontline staff/clinician concerns.^{5,6} Additionally, leadership should be present and involved in daily debriefings⁴ and/or huddles¹ to provide real-time feedback to staff^{5,6} and prevent initiative erosion over time.¹ A critical component is leadership/organizational messaging^{4,5} to HCW, particularly stating genuine gratitude^{4,5,6} for their contributions⁴ and honoring their professional dedication.⁴ Additionally, these words should be followed by actions beyond messaging, such as items, tokens, or celebrations to recognize their extraordinary efforts.⁴

The projected significance of the HCW mental health impact³ is beginning to be seen with anecdotal stories of increased workloads, emotional stressors, and moral dilemmas in the rapidly changing COVID-19 environment^{1,5} (See above table). However, the risks, benefits, and fiscal impacts of COVID-based wellness programs are as yet unknown,² as many recently launched programs remain in the evaluation phase.² Easily accessed institution-specific resources can be designed and incorporated into these programs, such as self-directed apps, webinars, and websites^{3,6} (Table 1, Page 3; Web Resources, Page 4). Other key highlights of the evidence include:

- Healthcare workers want assurance that their organization will support them and their families.⁵
- Overall, wellness programs are multi-level^{1,2,3} and reflect individual, group, and system-wide capacity/resources.^{1,2,3,6}
- Wellness program initiatives must provide role clarity, incorporate algorithms/pathways,¹⁻³ and enlist engagement with skilled, competent mental health professionals¹⁻³ with rapid access when needed^{1,2,3,6} (Table 1, Page 3).
- Allocate adequate time HCW to feel comfortable with contributing concerns,¹ thoughts,¹ feelings;¹ then they can move from *I'm fine*¹ to more forthright *distress and anxieties*.¹
- A peer-to-peer program^{2,6} represents a high benefit, low risk, low cost intervention without specialized organizational resources for implementation.² However, this program may not be feasible during severe staffing shortages.
- Spirituality, religion, and culture were recognized as important elements in wellness practices and coping³

<i>Reoccurring Themes During Wellness Programs¹⁻⁶</i>	
<ul style="list-style-type: none"> • Sense of powerlessness¹ • Moral distress (deaths)^{1,3-5} • HCW stigma/privacy^{1-3,6} • Resource allocation¹⁻³ 	<ul style="list-style-type: none"> • Social/family disruption¹ • Economic security¹ • Absolute scarcity¹ • Personal safety¹

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Recommendations: It is difficult to measure the impact¹ of the COVID-19 pandemic, which remains an evolving event.^{1,2,4} Leaders must give thoughtful consideration regarding burdening staff with surveys/assessments and yet collect data for the most salient factors² such as resiliency², PTSD,¹ and burnout.¹ Frontline clinicians may have difficulty expressing their complex experiences, complicated grief, and deep mental distress over time.³ Nurses, respiratory care practitioners, building services, and other frontline staff face challenges in easily accessing specially-tailored mental health support.⁶ Wellness program teams/taskforces must take the time to reflect upon these profound lived experiences, adapt them to current environments, and evaluate the data-to-date to target customized interventions (0-12 months).^{3,4,6} Above all, healthcare systems must build and enhance workforce resilience¹⁻⁶ to *allow work issues to remain at work and leave the home environment as places of rest, recuperation, and relaxation.*²

The following recommendations are offered for interprofessional teams/taskforces to consider as they design, implement, and evaluate wellness programs for healthcare clinicians and HCW during the 2020 COVID-19 pandemic:

- Encourage frontline staff to ask for assistance and help, rather than making difficult decisions alone⁵
- Examine the challenges related to maintaining staff for mental health referrals while continuing to provide patient care.⁶
- Address the staff's physical needs first,^{1,3-5} then physical safety,^{1,4,5} followed by immediate needs for their respective families,^{1,4,5} childcare,^{1,4,5} transportation,^{1,4,5} and lodging,^{1,4,5} and lastly focus on their mental health wellness.^{1,3-5}
- Allow adequate time and trust to build staff rapport so they are at ease contributing concerns, thoughts, and experiences.¹
- Incorporate the use of models and algorithms to ensure a systems design approach.¹⁻³
- Design and incorporate healthcare specific self-directed resources such as peer-to-peer programs^{2,6}, apps, webinars, and websites.^{3,6} (See Page 4 for web links to digital resources)
- Build assessment and management components into the program, as well as immediate mental health needs^{1,2}
- Consider individual cultural and religiosity/spirituality elements during program design and interventions, both short-term, during COVID-19, and after the pandemic.³

Further investigation is warranted to examine the risks, benefits, and costs related to COVID-19 wellness programs,² exploring the clinician's unique COVID-19 experiences,¹ and determining the overall effectiveness of implemented wellness programs for frontline clinicians' and HCWs' mental health.¹⁻⁶

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Table 1.

Wellness Programs in the Time of COVID-19: Strategic Structures and Processes for Successful Outcomes

STRUCTURES <i>Science-Based Wellness Program¹</i>	PROCESSES <i>Overarching processes consist of self-directed, system directed, and mental health support³</i>	OUTCOMES <i>Build and enhance workforce resilience¹⁻⁶</i>
<p><u>Interdisciplinary Steering Committee</u>^{1,4,6}</p> <ul style="list-style-type: none"> • Senior Level Executive Champion¹ • Chief Wellness Officer^{1,4} • Physicians^{1,2,6} • Nurse Leaders^{1,2,6} • Social workers^{1,6} • Residents^{2,6} • Fellows^{2,6} <p><u>Wellness Group/Teams/Taskforces</u>^{1-4,6}</p> <ul style="list-style-type: none"> • Battle Buddies² • Rounding Teams^{1,4} • Behavioral Sciences¹ <p><u>Digital Infrastructure Support</u>^{3,6}</p> <ul style="list-style-type: none"> • Telehealth^{3,6} • Website Repository^{3,6} • Self-directed web resources (Page 4) <p><u>Human Resources</u>⁶</p> <p><u>Communications</u>^{4,6}</p> <ul style="list-style-type: none"> • Referral Pathway^{1,3} <p><u>Resources</u>^{1,3,6}</p> <ul style="list-style-type: none"> • Facilitator Guide⁶ • Pocket Cards⁶ • Posters⁶ • Algorithms + Flowcharts^{1-3,6} • Models^{1,2,4} • Infographs⁶ • Webinars³ <p><u>Wellness Resource Hub & Rooms</u>¹</p> <p><u>Competency Training</u>⁴</p>	<p style="text-align: center;"><u>SELF-DIRECTED</u></p> <ul style="list-style-type: none"> • <u>Peer-to-Peer Partnerships</u>^{2,6} (i.e., Battle Buddies²) <ul style="list-style-type: none"> ○ Mutually beneficial conversations² ○ Peers identify 2–3 people; neutral party selects;² no close friends or confidantes² ○ Pocket cards^{2,6} for peer-to-peer pairing² and include mindfulness techniques^{2,6}, verbal affirmations^{2,6} ○ Daily contact regarding challenges/successes with peer who provides insights and recommendations² ○ Discussion are for NOT airing criticisms.² Not a therapist’ not confidential therapy sessions.² ○ If peer observes excessive anxiety or behaviors, then therapeutic relationship offered and referral to MH consultant² <p style="text-align: center;"><u>SYSTEM DIRECTED</u></p> <ul style="list-style-type: none"> • Consider frameworks/models to structure an evidence-based program:²⁻⁵ <ul style="list-style-type: none"> ○ “Hear Me, Protect Me, Prepare Me, Support Me, Care for Me”³⁻⁵ (See article table⁵) ○ Anticipate-Plan-Deter (APD) Model² • Interdisciplinary Teams to build and lead evidence-based wellness program^{1,4,6} • Display visible leadership^{4,5} and genuine expressions of gratitude and recognition^{4,5} • Resource sharing via digital modalities,⁶ emails,⁶ huddles,¹ rounds,⁶ town halls,⁶ interdisciplinary meetings^{3,8} • Collaborate with IT,⁶ communications,⁶ and human resources⁶ <ul style="list-style-type: none"> ○ Incorporate basic logistical, communication, psychosocial, + MH support.⁵ • Frequent and regular leader communication⁶ and rounding via remote videoconferencing^{1,2} <ul style="list-style-type: none"> ○ Daily focused huddle with real-time feedback loops;¹ focus on units with heaviest COVID burden¹ ○ Build rapport¹ and share key findings,^{1,2} real-time feedback loop,^{1,2} resolve issues,² course correct² • Build HCW and Wellness Program capacity,² resilience² mechanisms across the healthcare system^{2,4,6} <ul style="list-style-type: none"> ○ Mentoring and oversight system for reassigned staff⁴ ○ Liaison peer-to-peer² and support group⁶ ventilation and expression² ○ Modify policies,⁴ reduce non-essential tasks,⁴ delegate other tasks⁴ ○ Network with other healthcare organizations⁴ • Anticipate immediate post-phase, long-term phase (3-6-12 month) for mental distress & complicated grief (6-12 month)³ <p style="text-align: center;"><u>MENTAL HEALTH (MH) DIRECTED</u></p> <ul style="list-style-type: none"> • Build MH capacity and mechanisms across system^{4,6} <ul style="list-style-type: none"> ○ Focus on listening,² validating,² sharing² ○ Build short- and long-term MH program outcomes³ ○ Website⁶ for expedited triage⁶ and telehealth linkage⁶ • Initiate customized remote group sessions with MH consultant² • Frontline staff to 1) identify stressors² and 2) most concerned about for peers² • Psych nurse immediate individual consult⁶ • Quick access^{1,3} and triage¹ to MH support teams^{1,3,6} and specialties^{3,6} • Wellness Resource Hub¹ room on COVID-19 unit staffed with MH providers¹ <ul style="list-style-type: none"> ○ Calm music,¹ lounge chairs,¹ healthy snacks,¹ self-reflection prompts on wall¹ • Wellness Plus:¹ designated area for staff in crisis with immediate MH assessment/intervention by experienced clinician¹ 	<p style="text-align: center;"><i>Allow work issues to remain at work, and leave home environment as places of rest, recuperation, and relaxation²</i></p> <p style="text-align: center;"><u>SELF-DIRECTED</u></p> <ul style="list-style-type: none"> • Support staff coping and recovery⁴ • Connect HCW to peers: “Leave no one behind”² • Assist early identification/support for at-risk HCW² <p style="text-align: center;"><u>SYSTEM DIRECTED</u></p> <ul style="list-style-type: none"> • Monitor leader availability, involvement, and visibility to hear, protect, prepare, support, and care for healthcare professionals^{1,4,5} • Examine potential for significant mental health impact³ • Measure organizational impact,² workforce resilience,² longer term outcomes² • Continuous modification of provided resources/services^{2,6} • Fund MH resources for program needs² • Ensure MH resources/consultations are offered to all HCW that addresses diversity^{1,2,3,6} and culture³ • Track website hits of resources to determine continued need and support^{1,6} <p style="text-align: center;"><u>MENTAL HEALTH DIRECTED</u></p> <ul style="list-style-type: none"> • Build HCW physical and psychological wellbeing, self-efficacy,² hope² to mitigate burnout,² PTSD,¹ and complicated grief³ • Design services from elicited feedback to address expressed needs^{4,6}

COVID-19 Wellness and Mental Health Resource Websites

- **Veterans' Health Administration: PTSD and COVID-19 Apps³**
<https://www.ptsd.va.gov/appvid/mobile/index.asp>

- **National Center for PTSD: Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak³**
<https://www.ptsd.va.gov/covid/COVID19ManagingStressHCW032020.pdf>

- **Sleep Health During COVID-19, Center for the Study of Traumatic Stress, Uniformed Services University³**
https://www.cstsonline.org/assets/media/documents/CSTS_FS_Fight_COVID19_w_Better_Sleep_Health.pdf

- **COVID-19 Mental Health Responders, Harvard University³**
https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2555/2020/03/HSPH-COVID-19-mental-health-tips-3-11-20_kk.pdf

- **Guidance for Leaders in Communicating Loss and Death³**
https://www.cstsonline.org/assets/media/documents/CSTS_FS_Grief_Leadership_During_COVID19.pdf

- **Mount Sinai in New York City: Website of resource⁵**
<https://www.mountsinai.org/about/covid19/staff-resources/well-being>

- **Department of Defense: Dealing with Traumatic Stress⁵**
<https://www.cstsonline.org/>

- **Dr. Mark Greenwald (Carilion Clinic, VA) is sharing a platform created for physician buddy support⁵**
<https://www.peerrxmed.com/>

- **New York Times article on anticipated traumatic stress⁵**
<https://www.nytimes.com/2020/03/29/opinion/coronavirus-ventilators-rationing-triage.html>

- **Stanford COVID-19 Clinical Research Response⁵**
<https://med.stanford.edu/cme/COVID19/education.html#on-demand-webinars-&-%20videos>

- **Videos: Caring for Yourself & Others During the COVID-19 Pandemic: Managing Healthcare Workers' Stress⁵**
<https://www.theschwartzcenter.org/webinar/caring-for-yourself-others-during-the-covid-19-pandemic-managing-healthcare-workers-stress>

- **University of North Carolina Psychiatry: Mental Health and Well Being Survival Guide Webinar⁵**
<https://www.youtube.com/watch?v=Endyyx84w98&t=2s>

Review References

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2. Albott, C.S., Wozniak, J.R., & McGlinch, B.P., Wall, M.H., Gold, B.S., & Vinogrado., S. V. (2020). *International Anesthesia Research Society*, XX(XX), 1-12). DOI: 10.1213/ANE.0000000000004912
3. Rauch, S.A., Simon, N.M., & Rothbaum, B.O. (April 30, 2020). Phased approach for supporting the mental health of healthcare workers and other affected by the COVID-19 pandemic (PAC). *Anxiety and Depression Association of America*. Accessed July 17, 2020. <https://aaa.org/sites/default/files/PhasedApproachtoCovid-19.ver1.2.pdf>
4. Shanafelt, T.D., Ripp, J., Brown, M., & Sinsky, C.A. (2020). Caring for healthcare workers during crisis: Creating a resilient organization. *American Medical Association*. Accessed July 20, 2020. <https://www.ama-assn.org/system/files/2020-05/caring-for-health-care-workers-covid-19.pdf>
5. Shanafelt, T., Ripp, J., & Trocket, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *JAMA*, 323(21), p. 2133-2134. doi: 10.1001/jama.2020.5893
6. Spray, A., Patel, N.A., Sood, A., Wu, S.X., Simon, NM., Podbury, R., Vasserman, A., Caravella, R.A., Silverman, Y., Pochtar, R., Liaw, R., & Ackerman, M.G. (2020). Development of Wellness Programs During the COVID-19 Pandemic Response *Psychiatric Annals*. 50(7):289-294 doi.org/10.3928/00485713-20200613-01

Additional Resources

7. Blake, H., Bermingham, F., Johnson, G., & Tabner, A. (2020). Mitigating the psychological impact of COVID-19 on healthcare workers: A digital learning package. *International Research and Public Health*, 17(2997), 1-15. doi:10.3390/ijerph17092997
 - Free open-source software Xerte for authoring learning objects, developed by the University of Nottingham in the UK. Download from the Xerte Community website at <https://www.nottingham.ac.uk/xerte/index.aspx>
8. Cartwright, J. & Thompson, A. (2020). Introducing psychological strategies for healthcare professionals during COVID-19: An overview of the ACE COVID intervention. *Dermatological Nursing*, 19(2): 18-21. ISSN: 1477-3368.
9. Ripp, J., Peccoraro, L., & Charney, D. (2020). Attending to the emotional well-being of the health care workforce in a New York city health system during the COVID-19 pandemic. *Academic Medicine*, xxxx:xx:00-00. doi: 10.1097/ACM.0000000000003414
10. Walton, M., Murray, E., & Christian, M.D. (2020). Mental healthcare for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal: Acute Cardiovascular Care*, 0(0), 1-7.
11. World Health Organization. (2020). Looking after your mental health during COVID-19: Six tips for healthcare professionals. *Journal of Diabetes Nursing Volume*, 24(2), 1. Accessed July 20, 2020. <https://www.ama-assn.org/system/files/2020-05/caring-for-health-care-workers-covid-19.pdf>

Evidence Search Strategy Methodology

Evidence Search Strategies: A rapid review on the selected clinical question was conducted from July 17 to July 22, 2020. This review examined the evidence for the quantity, quality, and consistency of the evidence for wellness programs specific to healthcare clinicians and healthcare workers during the 2020 COVID-19 pandemic. The populations examined in this review were restricted to nurses, physicians, and healthcare workers. The environmental setting was restricted to the healthcare setting.

Search terms were broad and included “COVID-19,” “wellness programs,” “resilience programs,” “promotion of health,” “moral injury,” combined with “mental health,” “spiritual health”, “health campaigns”, “emotional well-being”, “burnout mitigation programs”, “nurses”, “physicians”, “clinicians” OR “healthcare workers” either alone or in combination. Electronic databases included PubMed, CINAHL, Google Scholar, Google, and Yahoo. Searches were individualized for each database for the year 2020. See Pages 8 and 9 for details.

This review yielded 1305 relevant hits after initial de-duplication between databases. 83 articles were selected for inclusion. 3 rounds of detailed examination of abstracts and full text articles resulted in the elimination of 60 articles, as they did not answer the clinical question, were outside the healthcare environment or focused on concepts other than appropriate concepts related to the topic of interest. 5 articles were identified that pertained to the clinical area of inquiry. One additional contextual reference⁵ was added, as it was discussed in 3 review articles.^{3,4,6}

The articles were ranked using the Academy of Evidence-Based Practice Evidence Leveling System and graded using the Johns Hopkins Evidence Appraisal tools (Page 7). The strength of the evidence ranged from low to high quality, with a final grade of low quality due to the lack of rigorous research studies.

Evidence Review Results: The evidence consisted of expert opinion/commentary,^{3,4,5} performance improvement,² and best practices.^{1,6} The evidence was consistent regarding the major concepts, need, and structure/process/outcome components of wellness programs to promote resiliency and health during the COVID-19 pandemic (Table 1, Page 3). There are many limitations to this review, given the lack of research studies. The risks, benefits, and fiscal impacts of COVID-19 based wellness programs are as yet unknown,² as many recently launched programs remain in the evaluation phase.² It is difficult to measure the impact¹ of the COVID-19 pandemic, which remains an evolving event.^{1,2,4} Although authors describe the high benefits, low risks, low costs of the peer-to-peer intervention, a buddy program may not be feasible during current severe staffing shortages. Further investigation is warranted to examine the risks, benefits, and costs related to COVID-19 wellness programs,² exploring the clinician’s unique COVID-19 experiences,¹ and determining the overall effectiveness of implemented wellness programs for frontline clinician and HCW mental health.¹⁻⁶

**Academy of Evidence Based Practice® (EBP)
Evidence Leveling System (ELS)**

7

LEVEL	DESCRIPTION	RELEVANT ARTICLES	EVIDENCE TYPE
A	Meta-analysis of multiple large sample or small sample* randomized controlled studies, or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment		
B	Well-designed controlled studies, both randomized and nonrandomized, prospective or retrospective studies, and integrative reviews with results that consistently support a specific action, intervention, or treatment		
C	Qualitative studies, descriptive or correlational studies, concept analyses, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results		
D	Peer-reviewed professional organizational standards, with clinical studies to support recommendations		
E	Theory-based evidence from expert opinion or multiple case reports, case studies, consensus of experts, and literature reviews	6	#1 Adibe: Best Practice #2 Albott: Evidence-Based Performance Improvement #3 Rausch: Expert Opinion #4 Shanafelt, Ripp, Brown: Commentary/Expert Opinion #5 Shanafelt, Ripp, Trocket: Commentary/Expert Opinion #6 Spray: Best Practice
MA	Manufacturer's recommendation; Anecdotes		
LR	Laws and Regulations (local, state, federal; licensing boards; accreditation bodies, etc.)		
Total		6	

* A large sample has adequate power to detect the observed effect with confidence (as seen in significant Confidence Intervals). A small sample may lack confidence in the power of the desired effect (Polit & Beck, 2008). Designed by Emma M. Cuenca and Cecelia L. Crawford, Academy of EBP; ©Kaiser Permanente SCAL Regional Nursing Research Program, May 2011. Adapted from AACN Evidence Leveling System (2009) and Canadian Medical Association & Centre for Evidence-Based Medicine, Levels of the Evidence (2001)

John Hopkins EBP Research/Non-Research Appraisal Grading

High Quality: Articles = #1, #2, #3, #6

(Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence OR expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader in the field)

Moderate Quality: Articles = 0

(Reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence OR expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions)

Low Quality: Articles = #4, #5

(Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn **OR** expertise is not discernable or is dubious; conclusions cannot be drawn.)

Final Summary of the Body of Evidence: Low Quality

Although citations were ranked between low-to-high, the final appraisal grade for the quality of the evidence was deemed **low quality due to the lack of rigorous research studies**, as the evidence was expert opinion, commentary, performance improvement, and best practices.

Date: July 17 to July 23, 2020

Clinical question: What is the quantity, quality, and consistency of the evidence for Wellness Programs specific to healthcare clinicians and healthcare workers during the 2020 COVID-19 pandemic?

All searches for Year 2020

Database	Key Word(s) and/or Controlled Vocabulary Terms	References Identified (hits)	Relevant References	Duplicate Articles	Articles for Review	Articles Excluded	Relevant References
PubMed 1	Wellness Programs Covid Healthcare Workers OR Burnout Mitigation Programs Covid Healthcare Workers OR Moral Injury Covid OR healthcare workers covid-19 pandemic resilience OR MM"COVID-19" AND MM"Health Personnel" AND MM"Support, Psychosocial"	360	34	0*	34	33	1
PubMed 2	Wellness Programs AND COVID AND employees	9	1	1	0	0	0
CINAHL 1	healthcare workers covid-19 pandemic resilience	3	2	1	1	1	0
CINAHL 2	wellness programs AND well-being AND COVID-19 AND healthcare professionals AND health workers AND health employees AND Physicians AND nurses, first respondents, clinician AND COVID, wellness AND healthy AND workers AND COVID-19	27	17	3	14	13	1
Google Scholar	Wellness and healthcare workers and COVID	905 (5 pages)	23	10	13	11	2
Google	Mind-body wellness program COVID healthcare workers	3,380,000	2	2	0	0	0
Yahoo	peer reviewed articles on wellness program and COVID and healthcare employees OR wellness program and COVID-19 and healthcare employees	298,120,000	4	1	3	2	1
	TOTALS	1305 (without browsers)	83	18	65	60	5

#Controlled vocabulary (subject terms, MESH terms, tagged terms specific to database)

*Use the first database as the main comparison for subsequent database searches and identifying duplicate articles

*Reference/Contextual Links
Frequently Cited Reference: Shanafelt, T., Ripp, J., & Trocket, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. <i>JAMA</i> ,323(21), p. 2133-2134. Doi: 10.1001/jama.2020.5893

Total Articles Included in Literature Review: Database (5) + Contextual Links (1) = 6

Clinical Question				
Population and/or Patient(s)	Intervention/Interest Area	Comparison Intervention (Often current practice)	Outcome	Time Period (If Applicable; Optional)
P: Healthcare clinicians and healthcare workers	I: Wellness Programs	C: Current practice	O: Resiliency and health	T: During COVID-19 pandemic
Final Clinical Question: What is the quantity, quality, and consistency of the evidence for Wellness Programs specific to healthcare clinicians and healthcare workers during the 2020 COVID-19 pandemic?				

Searchable Question
Key Search Terms: COVID-19; Wellness Programs; moral injury; mental health; resiliency (and other related concepts); healthcare staff; clinicians; nurses; physicians; healthcare workers
Inclusion Criteria: COVID-19; Nurses, Physicians, other healthcare workers (HCW); Wellness Programs; acute care & ambulatory care
Exclusion Criteria: Other conditions than COVID-19; other programs not related to Wellness Programs; other persons not in healthcare; setting other than acute & ambulatory care
Limitors (Open year or year ranges, age ranges, and language, etc.): 2020 Only; English only
Databases: PubMed, CINAHL, Google Scholar; Google, Yahoo

Purpose/intended Audience

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These documents have been developed to assist clinicians by providing an analytical framework for the effective evaluation and treatment of selected common problems encountered in patients. These documents are not intended to establish a protocol for all patients with a particular condition. While evidence reviews provide one approach to evaluating a problem, clinical conditions may vary significantly from individual to individual. Therefore, clinicians must exercise independent professional judgment and make decisions based upon the situation presented.

Kaiser Permanente's documents were created using an evidence-based process; however, the strength of the evidence supporting these documents differs. Because there may be differing yet reasonable interpretations of the same evidence, it is likely that more than one viewpoint on any given healthcare condition exists. Many reviews will include a range of recommendations consistent with the existing state of the evidence.

All of the Kaiser Permanente integrative reviews and evidence summaries were developed from published research and non-research evidence and do not necessarily represent the views of all clinicians in Kaiser Permanente. These documents may also include recommendations that differ from certain federal or state health care mandates.

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