

Operational Stress Control Service

An Organizational Program to Support Health Care Worker Well-Being

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Objective: This manuscript details the methods, outcomes, and lessons learned from a successful multi-dimensional, interdisciplinary, institutional response to HCW well-being during the COVID-19 pandemic. **Methods:** Operational Stress Control Service (OSCS) is a model for the prevention and management of stress and trauma implemented within an occupational system. Communication, Employee Wellness, and Intervention were targeted program aspects, adapted from an established US military protocol. **Results:** Since April 2020, OSCS has received 4660 unique survey responses; reached 1007 employees in-person; informed 125 leadership-hosted videoconferences; and assisted 13 departments with grief and morale-related challenges. **Conclusions:** OSCS improved communication across the organization and allowed for rapid deployment of solutions to maintain effective operations. Results highlight the benefit of multiple avenues of frequent, bottom-up, and top-down communication. Creating such services during times of normalcy might be considered in preparation for future crisis.

Keywords: burnout, COVID, employee wellness, healthcare workers, prevention, stress, system interventions

The COVID-19 pandemic has brought about unprecedented strain on the mental health and well-being of health care workers (HCWs), from those involved directly with patient care to those providing ancillary services, such as janitorial and food staff.¹⁻⁴ Interventions for HCWs are critical to prevent burnout and maintain optimal functioning. This is particularly true during the extraordinary circumstances that occur around a pandemic, increasing the demand for health care, creating a high risk of infection,

increased likelihood of exposure to primary/secondary trauma, and increased potential for emotional and moral injury.^{2,5}

Since the start of the pandemic, there have been a number of articles, brief reports, editorials, and letters published detailing institutional responses to mitigate detrimental effects on HCW well-being.⁶ These responses have included dedicated emotional support lines,⁷ disseminating information about wellness to employees,^{8,9} offering wellness services to employees,^{7,9-11} a peer support program,¹² as well as establishing an entire center dedicated to wellness services (eg, meditation spaces, yoga classes) for employees.^{11,13} Although there are exceptions, most of these interventions either focus on mitigating immediate crisis or rely on employees to take advantage of newly available resources and programming. This article details the creation, outcomes, and lessons learned from an intervention based on a US Military program deployed within a multi-site healthcare system during the COVID-19 pandemic. This program actively engages employees to identify challenges and creates a feedback loop between employees and leadership to rapidly respond to issues as they arise.

Foundation: Combat Operational Stress Control

Combat Operational Stress Control (COSC) is a US Military program that was designed to mitigate and reduce the effects of stress on service members and increase both unit and individual resilience to promote mission readiness and performance.¹⁴ In short, it was designed to identify and address service member stress management and resiliency to stress injury (ie, emotional injury caused by intense or prolonged exposure to stress) in any operational environment. This program was developed on the premise that stress behaviors can be measured on a continuum: Ready, Reacting, Injured, and Ill.¹⁴

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This work was supported by resources of the W. G. (Bill) Hefner Veterans Affairs Health Care System, and the Mid-Atlantic (VISN 6) Mental Illness Research, Education, and Clinical Center (MIRECC).

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Supporting materials related to OSCS can be requested from the corresponding author.

The views, opinions and/or findings contained in this article are those of the authors and should not be construed as an official US Department of Veterans Affairs position, policy or decision, unless so designated by other official documentation.

The authors report no conflicts of interest.

Clinical significance: Burnout in healthcare workers has been highlighted as a key concern during the COVID-19 pandemic. Operational Stress Control Service can be easily and readily implemented in both times of normalcy and crisis to both systemically support and effectively address healthcare worker concerns.

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DOI: 10.1097/JOM.0000000000002352

Prevention measures are in place at all levels; however, once signs of increasing stress and negative outcomes from that stress are identified, actions to reduce and prevent continued worsening are implemented. Importantly, the focus goes beyond the individual, and includes both the unit and family.

Parallels and Application to a Health Care Setting

There are a number of similarities between HCWs and service members, both in internal motivation as well as work environment. Like service members, HCWs often have a strong sense of duty and feelings of great responsibility to others and the mission. This often leads to great personal sacrifice, including missing important family events and holidays due to work-related responsibilities. HCWs are also at-risk for contracting illness, as well as heavy mental health burden from burnout and emotional trauma.^{2,5,15} Specific to the pandemic, there is an amplified fear of unknowingly transmitting infection, such as exposing family members to the virus contracted in the healthcare setting. Cultural norms can be a powerful influence in the lives of HCW, often resulting in working beyond capacity and through illnesses. HCW also often experience stigma about seeking support or treatment for mental health.^{16–18}

Another similarity between HCWs and service members is the division into specialized units or groups and the strong sense of camaraderie that can form within these units.¹⁶ Therefore, interventions designed to work within that framework are ideal for adaptation to other institutions with a similar structure. Overall, these similarities make HCWs an ideal population to apply interventions that have been successful within a military framework.

Objective

This article describes a successful multi-dimensional, interdisciplinary, institutional response to HCW well-being based on COSC framework. This intervention utilized many program aspects deployed at other hospitals. A unique aspect of this response was the incorporation of an additional informational feedback loop component. This feedback loop allowed rapid bottom-up information gathering to be utilized by medical center leadership to direct implementation of, and access to, services. Our program, Operational Stress Control Service (OSCS) is based on the design and principles of COSC. Though not the only program based on military practices,¹² it is unique in the creation of a rapid feedback loop between employees and leadership to directly and quickly address concerns. The methodology and systemic outcomes from this intervention are detailed by parallel subsections in the “Method” and “Results” of this article. This has effectively mitigated employee stress (eg, due to frequently changing information and/or unclear guidance) and improved bidirectional communication during the pandemic.

METHOD

OSCS was implemented at a multi-site United States Department of Veterans Affairs (VA) Health Care System (VAHCS) encompassing a primary medical center and three associated healthcare center facilities (3321 employees across all facilities as of February 2021). OSCS operations were interdisciplinary and included departments of Mental Health, Research, Social Work, Whole Health, Chaplaincy, Employee Occupational Health, and Public Affairs, as well as medical center leadership. The core OSCS team met weekly to discuss input from the bottom-up sources (ie, non-supervisory and mid-management level employees to leadership), current events likely to affect medical center staff, potential system-level responses, prepare presentations for leadership, and problem solve challenges to the service functioning.

COSC was adapted to VAHCS operations by focusing on three broad components: Communication, Employee Wellness, and Intervention. The aspects of *Communication* and *Employee Wellness* focused on

gathering information about employee well-being and needs, providing reports and recommendations to leadership, and then leadership response. The third aspect, *Intervention*, was the OSCS response to crisis events. These different aspects are described in detail below.

Communication

OSCS implemented rapid *bottom-up* communication through anonymous online employee wellness surveys and brief in-person visits (*walk-abouts*) conducted by employee volunteers, some of whom were in department leadership roles. Additionally, rapid *top-down* communication occurred through a regularly scheduled videoconference presented by medical center leadership (*Link with Leadership*; LWL) and timely dissemination of information in response to employee needs, both by e-mail and accessible areas on the intranet. The combination of these bottom-up (ie, employees to leadership) and top-down (ie, leadership to employees) lines of communication created a rapid feedback loop (see Fig. 1) that allowed for the identification of and respond to concerns and issues in an efficient and timely manner.

Employee Wellness Surveys

The primary purpose of these surveys was to monitor the stress level of hospital staff and to collect timely information about evolving needs and concerns. These were developed and refined based on needs and current events. At the beginning of the pandemic, surveys were disseminated weekly. As the health care system adjusted back to more predictable operations, the schedule of surveys fluctuated commensurate with anticipated need. For example, survey frequency increased as clinics reopened or increased toward normal capacity. Survey distribution frequency was then decreased as operations stabilized.

Survey questions changed regularly based on current needs and events. They were as brief as possible to reduce burden on employees, with a target completion time between 5 and 7 minutes. Early survey versions consistently included measurement of employee stress levels and emotional burden. All surveys also included free-response fields with requests for LWL topics as well as questions or concerns that needed to be brought to the attention of the Medical Center Director (MCD). Examples of other question themes include interest in services (eg, classes offered to employees), availability of resources (eg, gloves, masks, etc.), value felt as an employee, communication (eg, barriers, suggestions, preferred method), and suggestions to improve the work environment. Additionally, use of OSCS resources was queried (awareness, use, hesitancy to use). More than 200 unique questions were asked across all surveys. Links to the survey were sent to all medical center employees directly from the MCD, with a summary of what was learned from the previous survey as well as new procedures implemented as a result. Surveys were anonymous to encourage honesty and openness. Following each survey, a report with aggregate information was created to be presented to leadership during Command Consultation (see below).

Walk-abouts

*Walk and talk therapy*¹⁹ was the inspiration for this aspect of OSCS, which is a simple intervention and means of communication whereby individuals informally check in with employees in a personal, face-to-face interaction. OSCS deployed staff volunteers to complete *walk-abouts* across the system in different areas of the medical center across all sites. Volunteers were not in hospital leadership, though some were in departmental supervisory roles, to encourage more openness from employees. These encounters involved speaking to staff (masked and socially distanced in compliance with regulations) about how they were doing, and asking if there was any support, information, or supplies they needed. The information from each walk-about was entered into a database by the staff member using a templated *after-action* report with free-text and slider-bar responses. This report

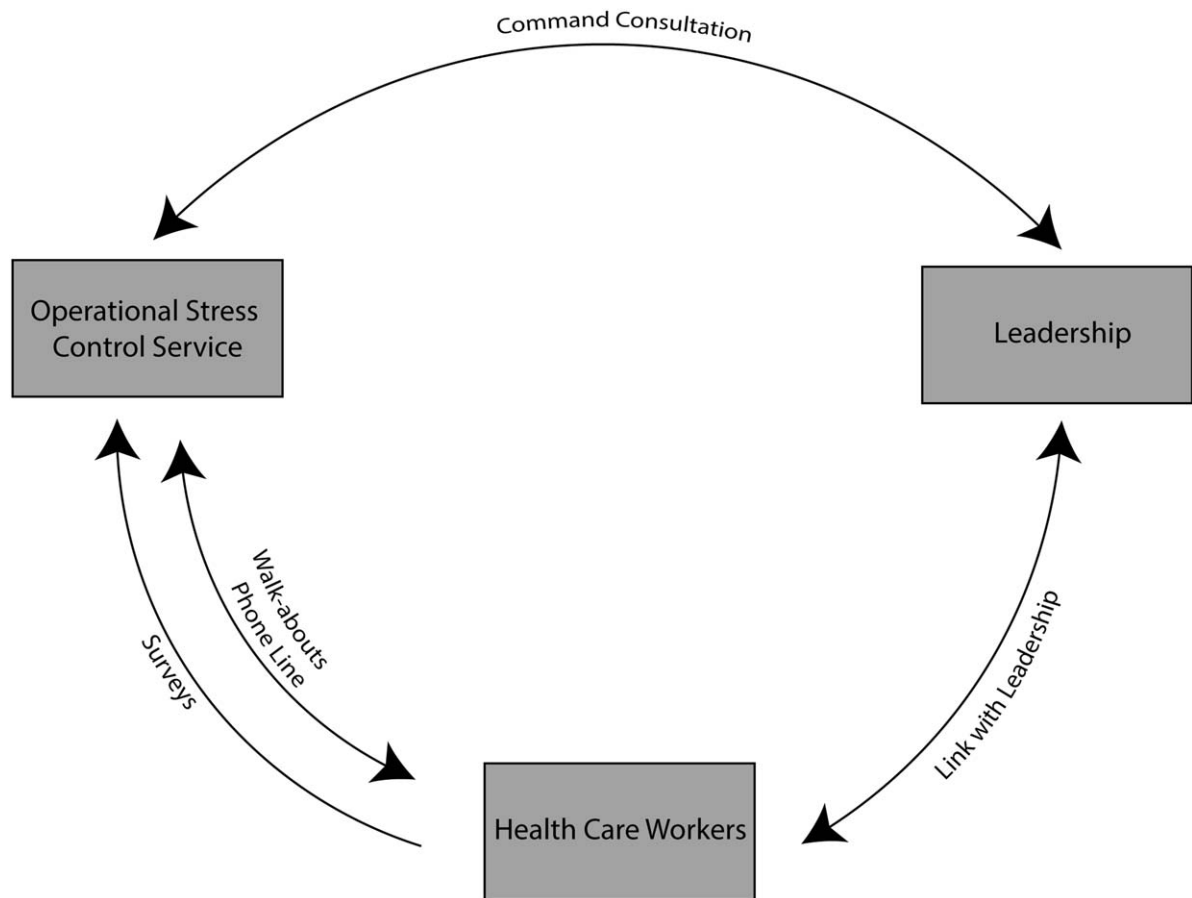


FIGURE 1. Simplified diagram detailing main components of the informational feedback loop. Several bidirectional modes of information gathering and dissemination, and communication were established as part of Operational Stress Control Service (OSCS). The three key hubs of communication were OSCS, health care system leadership, and the health care workers within the organization.

provides information about encounters, needs, and impressions of employee well-being. Staff also rated the level of perceived stress and employee receptiveness during the interactions.

Walkabouts served several purposes. First, they include a “human element” and increased visibility and accessibility to OSCS as a resource that employees can utilize when needed. Consistently, volunteers reported in the follow-up surveys that the interactions were appreciated, and many found that providing space to simply vent for a few minutes was therapeutic for the employees. Second, walkabouts provided a method for disseminating information and resources through handouts, brochures, or word of mouth. This was particularly useful given the increase in e-mail traffic amid the pandemic, increasing the number of e-mails that were missed or simply ignored. Last, walkabouts provided access to employees who might not regularly access e-mail (eg, grounds, maintenance, engineering, food service).

Command Consultation

The OSCS team provided weekly briefings to the MCD about what was learned from the employee survey and walkabouts. In turn, the MCD would provide OSCS with topics that leadership would find relevant and informative at the time (eg, how many employees plan to receive the COVID-19 vaccine). This provided a clear, mutually beneficial exchange of information, and allowed the MCD to address rumors, clarify points, and directly act on needs expressed by employees in a timely manner.

Link with Leadership

This was an hour-long videoconference that included the MCD, an Infectious Disease Specialist, and guest speakers. The MCD would begin LWL by addressing concerns or feedback from the most recent Employee Wellness Survey, which could include (but was not limited to), clarification about new procedures (eg, masking), addressing rumors (eg, hazard pay or bonuses), providing information about status and issues (eg, supply of personal protective equipment), and acknowledging specific employees or departments for positive actions. Following this, the Infectious Disease Specialist would review daily local, state, and national COVID-19 numbers and trends, and then provide other important information related to the virus, including transmission, protective measures, and information about the vaccines. For most LWLs, a guest speaker provided a brief presentation. These individuals either represented a service line (eg, police, engineering, research, social work) that discussed COVID-19 protocols that may be useful to adopt in other areas of the medical center or include resources available to other staff, community partners (eg, surrounding county school board directors, representatives from other hospitals) who discussed relevant regional actions and community resources, or the Whole Health Director to discuss health and wellness practices (eg, mindfulness, healthy eating). The MCD directly answered employee questions entered into the chat function at the end of the videoconferences.

LWL was provided daily for approximately 1 hour during the early stages of the pandemic and reduced in frequency (to twice- and once-weekly) commensurate with return to normal operations. Invitations to the videoconference were sent to all employees and supervisors were encouraged to allow employees time to attend. These presentations proved highly effective at keeping employees informed, engaged, and acknowledged, according to responses on the Employee Wellness Survey. For some employees, it was not possible to attend this regularly scheduled call, thus the calls were recorded and made available on the health care system intranet for employees to view at a later time.

Employee Wellness

Employee wellness included programs and resources to learn new stress management techniques as well as the opportunity to engage in them directly. These programs were abundant and readily available to staff both during and outside of work hours. All informational resources were advertised and/or made available on the OSCS resource page on the medical center intranet website.

Employee Whole Health

Whole Health (WH) is a relatively new US Department of Veterans Affairs initiative that focuses on supporting overall well-being, rather than a focus on specific diagnoses or disease states. During the pandemic WH expanded beyond previous wellness offerings and employed new services specifically aimed at HCWs to prevent burnout and crisis. Many resources were available nationally²⁰ (eg, brief guided mindfulness, meditation, yoga) and information was disseminated to all employees locally by e-mail, informational posters, as well as through presentations (eg, LWL, unit briefings, walk-about). Though traditionally focused on patient health and wellness, staff from WH volunteered to lead separate classes for interested employees. For example, several staff in one of the outlying clinics facilitated a weekly group mindfulness session through videoconference. Classes were detailed with a centralized calendar. Additionally, employees were offered the opportunity for a no-charge 1-year membership to an online wellness program, which included live, virtual access services such as meditation, mindfulness, yoga, and tai chi.

Resources

OSCS recognized additional challenges facing staff, including stigma, denial, and other work-related stressors. In response, additional resources were created by OSCS (ie, supervisor toolkit, stress and the brain handout, child care resources) or existing resources were increasingly advertised (eg, Employee Assistance Program handouts, financial resources related to difficulties induced by the pandemic, availability of childcare during school closures). A pocket card (*How Stress Affects the Brain*) was created that detailed how chronic stress affects the brain for volunteers to disseminate during walk-about. This was specifically developed to address cultural norms among HCW that create stigma around acknowledging a need for help and engaging in programs to address those needs. This card provided concrete health-related information about negative effects of stress on performance at work to highlight the importance of mitigating stress. In addition, a *Burnout Prevention* handout was created.

During the pandemic bottom-up data identified that many individuals in mid-level management (employees that supervise small groups of employees, but report to a supervisor themselves) were disproportionately stressed due to the pandemic. This related to struggling with issues such as: low staffing levels, protecting patients and staff, employee morale, and receiving messaging about self-care despite limited opportunity or time to engage in available programming. Recognizing this, a *Supervisor Toolkit*

was compiled and made available to all employees through the intranet. The *Supervisor Toolkit* included handouts for supervisors for personal use and to provide to their staff. Handouts included ways to begin meaningful conversations and methods to adjust to telework and mobile health, among others. Contact information for OSCS and the EAP were included in every communication from the MCD that contained potentially disconcerting information.

Intervention

Interventions encompass direct-to-employee and unit-level activities that are coordinated and tailored to specific needs, depending on the situation. Interventions were used to address disproportionately high stress and crisis, such as when coworkers passed away (due to COVID or otherwise), in times of work overload and burnout (ie, due to varying levels of coworkers out on sick leave), or by request. An initial needs assessment was conducted prior to OSCS implementation to determine interest in services, which involved a survey sent to supervisors to gauge overall interest and specific needs. An online request portal was created allowing employees and/or supervisors to request any of the OSCS interventions. For both the COVID support line and Traumatic Event Management (TEM; described below), volunteers completed the same after-action report as walk-about volunteers.

Unit Briefings/Unit Support Requests

Individuals/service lines are able to request services or consultation for specific needs. *Unit Briefings* can be scheduled to inform supervisors and employees about OSCS offerings and also serve to collect information about what units needed so resources can be created or identified and supplied. This mechanism has also been used to assist supervisors that have identified issues within their service line by providing direct support and coaching to restore optimal function and communication.

COVID-19 Telephone Line

A dedicated phone line was created to respond to COVID-19-related questions, concerns, and crises from employees. The phone line, set-up with a phone without caller ID to allow for anonymity, was staffed by mental health volunteers during first shift working hours, Monday through Friday. Posters advertising the phone line were posted throughout all facilities. Although the EAP has always been available as a national program for VA employees, the COVID-19 phone line offered local assistance for specific needs on a less formal and anonymous basis.

Traumatic Event Management

TEM was an available service prior to deployment of OSCS. The specific focus of TEM is to normalize staff reactions to trauma, allow for discussion and processing of emotions, and connect employees to longer-term resources. OSCS was able to incorporate TEM as an available resource making access more readily available from a centralized location. The facility had traditionally responded to traumatic events informally, which included chaplains, social workers, and/or mental health providers. Typically, contact was made and services were offered when key individuals learned of an event likely to cause extreme stress to staff (eg, death of an employee, September 11, 2001 attacks, unexpected death of a child on facility grounds, shooting in the Emergency Department).

Incorporating TEM services into OSCS offered a formalized system for departments to request specific services as well as an assignment and tracking system to follow up on assistance provided. The structure of OSCS TEM services created an opportunity to educate staff and leaders about available services as well as how to access them. In addition, TEM within OSCS offered a consistent and confidential communication system about traumatic events and

a formal mechanism to tailor the organizational response specifically to the needs of the situation.

RESULTS

Communication

The OSCS began functioning on April 4, 2020 and has been in continuous operation since that time. OSCS distributed a total of 20 surveys between April 2020 and February 2021. Of these surveys, there were 4660 unique responses, $M=233$ (range 118 to 407 responses per survey). Overall, this represents only between 3.6% and 12.3%, $M=7.0\%$, of the individuals employed across all sites ($N \approx 3321$) per survey. Notably, though telework was available for many service lines and many employees were teleworking for much of this time, most of the respondents, $M \approx 90\%$ (range = 86% to 94%), reported working in-person.

The MCD hosted LWL 125 times between April 2020 and April 2021. In the earlier months (April 2020 to August 2020), attendance was relatively high, $M=386$ (range 205 to 611). As interest in the pandemic naturally waned, attendance also decreased, with $M=223$ (range 108 to 329) attendees at LWL between December 2020 and April 2021. Notably, these numbers do not include the individuals who viewed LWL on intranet after it had been posted, or units that had a representative attend and disseminate information back to others.

Walk-about specifically targeted areas of the hospital where employees were less likely to use e-mail regularly to increase employee representation across the health care system. Since April 17, 2020, 143 walk-about have been conducted reaching 1007 employees across all sites. Receptiveness (0 to 100 scale; greater scores representing greater receptiveness) was lower at the onset, with some employees reluctant to engage in the novel interaction; however, receptiveness quickly increased and consistently remained high, $M \approx 81$.

Intervention

As OSCS was deployed, an initial Unit Needs Assessment was conducted with all departments to determine interest in OSCS resources. Overall, 25 unique services responded and were interested in offerings from OSCS; 78.9% included frontline clinical staff. Following initial Unit Briefings, requests for service were conducted through an online request form. Since then, the OSCS has been able to assist 13 service lines to overcome challenges related to employee morale and grief, among other difficulties.

The COVID-19 phone line was the least often used service as part of OSCS. Since its availability, 12 calls have been received (approximately 1/month average). Two callers reported extreme distress, six calls requested information about acquiring supplies (eg, plexiglass shields) or asking for COVID-19 related information (eg, accessing LWL, Families First Coronavirus Response Act [FFCRA] leave), and four calls were unrelated to COVID-19 (eg, wrong number). The survey indicated that most employees were aware of the phone line (81.3%). However, respondents reported that they were unlikely to utilize the phone line out of concern that the phone operator would be able to identify them. This highlights the benefit of multiple avenues of bottom-up communication.

Nine TEMs that were in response to deaths in the facility have been conducted since the start of the pandemic. Responses were coordinated with service lines and included grief support through e-mails and calls, or active group debriefing sessions for groups of individuals. Social Work and Chaplaincy coordinated these efforts.

DISCUSSION

OSCS has been an asset to this multi-site healthcare system during the pandemic. This multi-faceted approach to identifying employee challenges has increased awareness of, and ability to

respond quickly and effectively to, specific employee needs under these extraordinary circumstances. As an additional result of OSCS, numerous, sustainable developments have been implemented and improvements made for employees of this healthcare system.

Though the anonymous nature of the data collection instruments precludes us from providing specific analyses of program outcomes, there were three major features that we felt uniquely contributed to the effective implementation of this program. First, OSCS facilitated rapid communication and dissemination of information. In the dynamic environment of the pandemic, information flow through traditional chain of command avenues is protracted and inconsistent. The data gathering conducted by OSCS allowed employees a direct line of communication to medical center leadership. OSCS was able to swiftly filter information and provide concise, actionable findings for the MCD and other medical center leadership in real time.

Second, this program allowed accelerated responses by leadership to employee concerns and needs. LWL provided a platform for direct and frequent communication with employees. This platform was often used to respond directly to the most recent information gathered by OSCS. Further, information gathered by OSCS was able to help shape the form and style of communication utilized by leadership. OSCS evaluated what communication techniques were and were not working for employees and provide that information directly to leadership in a timeframe allowing for meaningful change.

Third, OSCS provided a centralized and easy to access point for all COVID-19 related resources. OSCS guided the development and refinement of local resources specifically targeted to the needs of employees. OSCS also capitalized on national resources for employees, increasing awareness, and accessibility of these resources.

Lessons Learned

The multidisciplinary nature of OSCS was a distinct advantage, and each member was able to contribute their specific expertise to operations. A multi-site healthcare system is a complex entity, and the knowledge provided from different specialties and occupations proved invaluable to implementing new resources and programs in addition to identifying existing solutions to problems that were identified. Additionally, this ensured that the burden of managing this ongoing operation was not placed on one service line (ie, department).

The bidirectional feedback loop and rapid pace of communication was invaluable and allowed leadership to quickly address issues and concerns. Responses were required on a time scale that matched the fast pace of change and dissemination of information across the health care system. Similarly, employee concerns and problems often changed weekly. For facility responses to be relevant, these issues and potential solutions needed to be identified quickly.

Several Service Chiefs (ie, Department Chairs) were actively involved in OSCS, attending weekly meetings to review data and discuss responses. Having buy-in and direct involvement of higher-level management facilitated rapid knowledge sharing and decision making. Specifically, OSCS was not required to seek approval after each hour-long weekly meeting because higher-level management was present. Therefore, it was possible to determine the feasibility of a response and the means through which it would be implemented because members of OSCS were not required to seek permission or resources to develop responses. These responses were then typically presented to leadership, either formally or informally, within 24 hours. This rapid development of responses to data was just as valuable as quickly acquiring the data. If responses had taken weeks to be developed and presented to medical center leadership, they would have become outdated and no longer useful to employees.

Obtaining information from multiple sources (eg, surveys, walk-about, LWL questions) was important. Foremost, this allowed a cross-check on information acquired from a single source. Confidence about the need to respond increased when the same concern was identified from multiple sources. Additionally, consistent feedback across sources was informative of center-wide operations and the use of different sources provides unique types of information. Specifically, surveys were valuable for overall impressions across the entire health care system; however, walk-about frequently identified needs specific to a location or unit.

Programs like OSCS can be valuable outside of the context of a pandemic. Several other national events occurred within the first year of OSCS, including reinvigoration of the Black Lives Matter movement, and the Capitol Hill riot. OSCS allowed the facility to do more than release a statement about these events and was able to identify specific ways these events affected employees. This in turn helped medical center leadership determine additional actions and responses to support employee well-being and communicate understanding. The effectiveness of the program in these contexts highlights both its sustainability and adaptability.

Limitations

Programs like OSCS require engagement from employees to be effective. Anecdotally, most employees felt OSCS was a valuable resource to have available during the pandemic; however, the vast majority did not engage. Completion of surveys took approximately 5 to 7 minutes and was regularly endorsed by the MCD, yet typically only about 7% of the work force was represented. This can be attributed to several factors, including lack of time to complete, workload, and not accessing a computer regularly for their position, among others. However, 90% of respondents were those who continued to work in-person throughout the pandemic, demonstrating significant lack of engagement from employees teleworking. Similarly, walk-about were unable to reach employees who teleworked, leaving these individuals underrepresented in the data. Most individuals endorsed a need for live programs such as mindfulness meditation or guided relaxation to address increased stress levels; however, actual attendance at these programs was poor. Our data suggests that HCWs do not have the time or flexibility in their schedule to realistically attend such programs, even if they know it would be helpful and desire to do so. It remains difficult to reach employees whose duties do not require the use of a computer. This includes engineering, groundskeepers, janitorial, food service, and retail staff. Additionally, some departments did not allow walk-about due to COVID-19 restrictions, notably inpatient medicine, surgery, and the nursing home/inpatient rehabilitation facility. Creativity and disproportionate effort are required to obtain data from these employees due to the nature of their positions.

CONCLUSION

OSCS is a unique service for HCW support, such that it contains several aspects of other programs deployed across medical centers, but additionally provided an informative feedback loop. This key feature allowed OSCS and leadership to continuously learn about employee needs and, in turn, gave leadership the ability to sift through employee needs to determine highest priority action-items that needed a fast response. OSCS greatly improved communication across the medical center through deployment of numerous new forms of bidirectional information exchange: although only 7% of staff responded to surveys, staff were able to engage in face-to-face communication via walk-about, utilize the phone line, participate in LWL, and have access to other forms of information distribution. The service also allowed for rapid deployment of solutions to maintain effective operations during the pandemic. Employee surveys or similar broad-based attempts at employee feedback are often nebulous with either a lack of or delayed outcomes. The immediacy

of the feedback systems for OSCS allowed for employees to directly see responses to their concerns. Other organizations, not just in healthcare, may also benefit from aspects of this model or a similarly embedded service. Creation of such services during times of relative normalcy might be considered in preparation for times of crisis that may arise in the future.

ACKNOWLEDGMENTS

We would like to thank individuals who have significantly contributed to the undertaking of the Operational Stress Control Service, including: Katherine H. Taber, Ryan Wagers, Cecilia Novitt, David Tobias, Lesley Reece, Laura Abood, D. 'Michelle' Gillespie-Gray, Lakeysa G. Rule, Priya Y. Patel, Angelina E. Kauffman, J.A. 'Andy' Roche, Frank Bettoli, Amy Anderson, Ashley Rose, John Allmond, Gwen Hampton, Stephen Russell, John Gaffney, Emily Lupson, Kristin Humphrey, Gus Diggs, Meghan Cody, Lester Thompson, Roshelle Bournes, Amy Jamerson, Quiana McDowell, Mary Berhalter, Rebecca Norman, Jessica Walker, Lynette Austin, Elizabeth Howarth, Shanyn Aysta-Isaac, Ann Williams, Bill Hayes, Dustin Meacham, Levonne Houston, and Brandon Smith.

We would also like to express our sincere appreciation for the fervent support from Mr. Joseph P. Vaughn, MBA, FACHE, Executive Director of the W. G. (Bill) Hefner VA Health Care System for ensuring the success of this service during the COVID-19 pandemic and beyond.

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