HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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Uproar as CDC Scales Back COVID-19 Testing

Infectious disease, public health groups condemn guidelines

By Gary Evans, Medical Writer

In a move widely seen as further evidence the pandemic response has been politically undermined, the Centers for Disease Control and Prevention (CDC) recently revised SARS-CoV-2 testing guidelines, de-emphasizing the need to test asymptomatic people who have been in contact with a case of COVID-19.[1]

The response from the infectious disease community was swift and severe, with many arguing that decreasing testing during a pandemic makes no sense and will lead to more infections.

"In a dramatic shift from previous federal guidelines, the CDC disclosed that some people without COVID-19 symptoms may not need to be tested, even though they may have been in close contact with an infected person," **Georges C. Benjamin**, MD, executive director of the American Public Health Association, said in a statement. "This is inconsistent with the evidence that shows up to 40% of individuals who are infected spread the virus asymptomatically. It is also unclear what problem this change solves."

> "THIS IS INCONSISTENT WITH THE EVIDENCE THAT SHOWS UP TO 40% OF INDIVIDUALS WHO ARE INFECTED SPREAD THE VIRUS [WITHOUT SYMPTOMS]."

The revision created an immediate problem for CDC Director **Robert Redfield**, MD, who tried to walk back the change by issuing a statement that conceded testing may

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MEDICAL WRITER: Gary Evans
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

be "considered" for all close contacts of confirmed or probable COVID-19 patients.

"We are placing an emphasis on testing individuals with symptomatic illness, individuals with a significant exposure, vulnerable populations including nursing homes or long-term care facilities, critical infrastructure workers, healthcare workers and first responders, or those individuals who may be asymptomatic when prioritized by medical and public health officials," Redfield stated. "Testing is meant to drive actions and achieve specific public health objectives. Everyone who needs a COVID-19 test can get a test. Everyone who wants a test does not necessarily need a test; the key is to engage the needed public health community in the decision with the appropriate follow-up action."

Testing, or lack thereof, has hobbled the U.S. response since the outbreak began. The CDC previously cited potential transmission from asymptomatic cases in emphasizing the importance of testing contacts of those with COVID-19. Posted Aug. 24, the revised language reads:

"If you are in a high COVID-19 transmission area and have attended a public or private gathering of more than 10 people (without widespread mask-wearing or physical distancing): You do not necessarily need a test unless you are a vulnerable individual or your healthcare provider or state or local public health officials recommend you take one."[1]

In his statement, Redfield summarized testing recommendations and mitigation techniques as follows:

- Testing may be considered for all close contacts of confirmed or probable COVID-19 patients.
- Symptomatic or asymptomatic contacts who test positive should be managed as confirmed COVID-19 cases.
- Asymptomatic contacts testing negative, or who are not tested, should strictly adhere to CDC mitigation protocols.
- If testing is not available, symptomatic close contacts should self-isolate and be managed as probable COVID-19 cases.

Anyone who has been in close contact with a confirmed or probable COVID-19 patient should follow these mitigation tactics:

- Monitor symptoms;
- Take special precautions to protect the vulnerable;
- Wear a mask;
- Stay at least six feet apart;
- Wash hands;
- Talk to a healthcare provider or public health expert determine if testing is needed.

Mixed Messages

The CDC action in part could be a real-world acknowledgement of the lack of rapid testing nationwide. But it drew a strong reaction because of a general perception that testing methods were improving and it would become easier to test contacts of suspected or confirmed COVID-19 cases.

"This has me and many other people in infectious disease and public health scratching our heads, because we were moving as a society to expanding testing," says **William Schaffner**, MD, a professor of preventive medicine at Vanderbilt University. "As testing becomes more available, less expensive, and the results can be returned more quickly, we were moving to greater use of tests — not reducing testing."

One problem is that tests —

depending on the test used and conditions under which it is given — may result in a false-negative, or less often, a false-positive. "False-negative tests provide false reassurance, and could lead to delayed treatment and relaxed restrictions despite being contagious," wrote **Robert H. Shmerling**, MD, senior faculty editor of *Harvard Health Publishing*. "False-positives, which are much less likely, can cause unwarranted anxiety and require people to quarantine unnecessarily."[2]

For example, the commonly used polymerase chain reaction (PCR) test with a nasal swab results in a range of false-negatives (2% to 37%). The reported rate of false-positives with this test is 5% or lower, Shmerling noted.

"The outside of the incubation period for [SARS-CoV-2] is 14 days," Schaffner says. "That is a very long period. We have all been trying to think of strategies that are valid and science-based to try to abbreviate that. We recognize that there is no perfect answer, but could we still reduce that duration and provide some assurance that the risk is very low?"

One tactic is to provide more testing to address the situation with false-negative tests. "There might be a way to do testing more frequently. If they are negative for several days, I would think that would reduce the risk that this contact is going to become positive," he says. "I thought we as a public health community were moving in that direction, trying to find testing as a means of providing some assurance that people could come out of quarantine a bit earlier. That is in conjunction with trying to move us back into a more functional society. This set of [CDC] advisories would appear to put the brakes on that."

Another troubling aspect of the testing change is the CDC presented no new data indicating spread from asymptomatic carriers is less of a concern than previously emphasized.

"I haven't seen any new data, but of course we understand a person who is a contact and quarantined is not likely to be a transmitter," Schaffner says. "[As a result of this change], we will be identifying fewer positive individuals."

Will this translate to more transmission? "Of course — exactly," he says.

Changes 'Indefensible'

Indeed, asymptomatic cases play a significant role in transmission of the novel coronavirus, said the Infectious Diseases Society of America. "The [CDC] revision is concerning, particularly as the United States continues to lead the world in confirmed cases and deaths, with more than 5.8 million cases and nearly 180,000 lives lost to the virus," the IDSA said in a statement. "Identifying individuals infected with COVID-19 — even if they are asymptomatic — is critical to support appropriate isolation and identification of contacts, to limit spread, and to provide the data-driven, comprehensive view of community spread needed to inform effective public health responses."[3]

The Society for Healthcare Epidemiology of America (SHEA) "vehemently" disagreed with the CDC testing changes, calling for an "immediate revision of these guidelines to underscore the criticality of testing and contact tracing as a primary means of combating the pandemic."

On the contrary, the country needs "dramatically increased testing," SHEA emphasized in a statement. "While the exact timing of such testing in relation to exposure can be debated, broad-scale testing is critically important because COVID-19 has been proven to be transmitted frequently by asymptomatically and pre-symptomatically infected persons."[4]

While acknowledging "the constraints of current testing capabilities," SHEA said the CDC is retreating from a basic principle of public health during outbreaks.

"The revised CDC guidelines are in direct contradistinction to evidence-based public health guidelines for identifying new cases of an epidemic disease, aggressively tracing contacts of new cases, and isolating and testing contacts known to be exposed," SHEA stated. "These principles are cornerstones of the public health management of an infectious disease epidemic."

SHEA urged the CDC to rescind the revised guidelines immediately and "include exposed contacts as individuals who need not only quarantine but also testing."

In a tweet, **Tom Frieden**, MD, former director of the CDC, called the revision "indefensible."

"If an asymptomatic contact tests positive, their contacts can be identified, warned, and quarantined," Frieden said. "Not testing asymptomatic contacts allows COVID to spread. The CDC guidance is indefensible. No matter who wrote it and got it posted on the CDC site, it needs to be changed."[5]

In his statement issued after the guidelines were revised, Redfield said, "CDC recently updated some of our testing guidance to reflect updated recommendations as to who should be tested. These updated guidelines, coordinated in conjunction with the White House Coronavirus Task

Force, received appropriate attention, consultation, and input from task force experts."

In a bizarre note that seems only fitting during the tragedy of errors that has been this nation's pandemic response, **Anthony Fauci**, MD — arguably the most respected infectious disease physician worldwide — told CNN he was literally unconscious during a surgical procedure when the testing revisions were made.

"I was under general anesthesia in the operating room and was not part of any discussion or deliberation regarding the new testing recommendations" said Fauci, a member of the White House Coronavirus Task Force and director of the National Institute of Allergy and Infectious Diseases. "I am concerned about the interpretation of these recommendations and worried it will give people the incorrect assumption that asymptomatic spread is not of great concern. In fact, it is."[6] ■

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Healthcare Workers Holding the Line Against Pandemic

But at what long-term mental cost?

Many have died and more have been sickened, but the nation's healthcare workers are grimly holding the line against the worst pandemic in a century. Those who survive may pay a mental health price, a "moral injury" not unlike soldiers returning from war, mental health experts warn.

The Institute for Healthcare Improvement (IHI) is addressing these current and looming issues through a series of webinars and papers on "psychological PPE [personal protective equipment]." The idea is that much as they don masks, gloves, and gowns, medical workers need "barriers" to protect their mental health.

"Every disaster brings with it a second disaster," said **Donald Berwick**, MD, MPP, president emeritus and a senior fellow at IHI. "The first is whatever the insult is — in this case, COVID-19 and the tragedies associated with it. The second is the behavioral health responses that occur both in the community and the workforce."

The COVID-19 pandemic is exacerbating existing issues with healthcare burnout that will persist even after the pandemic is under control. "We hypothesize that there is this population of staff who are currently operating in crisis mode and they are fully absorbing or experiencing the adverse effects, but over time will begin to show signs of psychological distress and trauma," said **Jessica Perlo**, MPH, director of IHI. "[Psychological PPE] includes behaviors and actions to support staff, like reducing fear and anxiety, promoting psychological safety, and facilitating peer support and connections. These behaviors and actions will continue to be critical as the pandemic continues as more staff need mental health support."

In a recent webinar, IHI explained how it reviewed evidence and interventions to develop the concept of psychological PPE, which can take many forms as it is adapted at the local level. IHI reviewed evidence on mental health techniques to develop a tool based on responses to natural disasters, terrorist attacks, and previous pandemics.

"It is not a checklist per se, but more like a menu of evidence-based options," says **Keziah Imbeah**, MSc, a research assistant on the IHI innovation team.

Support of the institution and administration is necessary for these programs to work "so [workers] feel free to take care of themselves as they are on the job and also as they step away," she said.

IHI recommendations include the following for individuals and team leaders:

Individual

• Take a day off and create space between work and home life.

• Avoid unnecessary publicity and media coverage about COVID-19.

• Receive mental health support during and after the crisis.

• Facilitate opportunities to show gratitude.

• Reframe negative experiences as positive and reclaim agency.

Team Leader

• Limit staff time on site/shift.

• Design clear roles and leadership.

• Train managers to be aware of key risk factors and monitor for any signs of distress.

• Make peer support services available to staff.

• Pair workers together to serve as peer support in a "buddy system."

A Personal Stake

Berwick has a personal stake in the issue, as his daughter is a physician at a Boston-area hospital.

"She is OK, but I can see the toll taken on her and many of her colleagues by the stresses of this dreaded disease — the deaths and despair around them and the risks they incur every day," he said at a recent IHI webinar. "She goes to work knowing she is exposing herself and her family to a very serious risk. She sticks with it and she is doing fine, but one should not underestimate the stress that it takes. My daughter is lucky in that she has a strong social support system, but that is not true of every healthcare worker."

The pressure goes beyond the clinical staff, as those who support the medical team face similar risks and stress, often with fewer resources. "We have to remember that the vast majority of healthcare workers are not people of high income. They are not people who have the prestige of being physicians or nurses," Berwick said. "These are people who work to keep the hospital going. They are the people serving the food, cleaning the rooms, and supporting the clinical staff. We know that they are under tremendous stress, including the stress of the economic downturn. Hospitals are not immune. Many healthcare workers, for example, don't even have health insurance."

People of color are more likely to have more serious infections with SARS-CoV-2. That means many healthcare workers are at additional risk as they care for COVID-19 patients.

"We also know the racial inequity that we are more and more aware of in the George Floyd era — but should have been aware of all along — selectively affecting African American, Latino, and Native American populations," Berwick said. "Those are heavily represented in the workforce at lower levels of income. That is another kind of stress, so this is crucial. Just like everything else we do, we need to bring science to bear. We need to understand what actually helps, get the data, and get the resources in place. Then, use the methods of improvement to bring those resources to the healthcare work force."

As many have noted, the pandemic may get worse before it gets better, with a convergence of novel coronavirus and seasonal influenza approaching in the fall.

"All the signals I'm seeing are that we are going to have a serious resurgence of this disease," Berwick said. "There are places already having that. I think even communities that have done well are going to be hit with a real serious problem. We still have not organized testing in this country as a strategy, and every other successful country has had totally different levels of surveillance. I think we are going to get hit again and probably pretty hard. I hope not, but we better get ready. This time, we don't need to be on our heels."

In statistics that are admittedly undercounts, the Centers for Disease Control and Prevention (CDC) reported as of Sept. 3, 151,998 healthcare workers have been infected with COVID-19 and 672 have died. The data were collected from 4.5 million people, but healthcare personnel status was only available for about 1 million. For the 151,998 cases of COVID-19 among healthcare personnel, death status was only available for 107,237. The CDC has previously estimated the actual number of infections may be tenfold higher than counted cases, meaning that more than a million healthcare workers have been infected in the pandemic and well over a thousand have likely died as a result.[2]

Protecting HCWs a 'Precondition'

Arpan Waghray, MD, a geriatric psychiatrist at Providence St. Joseph Health in Oakland, CA, said protecting healthcare workers was an immediate concern when the pandemic began.

"At Providence, we admitted the first COVID patient in the United States," he said. "Our system had to deal with a lot very early. As this started, our leaders made a strong commitment that the emotional well-being of our workforce is not just a priority; rather, it is a precondition for us to deliver excellence. This was brought into the command center discussions right from the very beginning."

Waghray and colleagues developed an electronic interactive stress meter with a range of emoji faces representing increasing levels of mental struggle. A range of resources are displayed depending on the stress level. Healthcare workers also can describe their specific problem and a preferred method of learning.

"You can say, 'I want help with anxiety and parenting during the pandemic, and my preferred method of learning is a podcast,'" he said. "The most commonly viewed topic in the last few months has been compassion fatigue. We found that telespiritual health was one of the most commonly used resources by those in the mild and moderate stress range."

The hospital also created a program allowing same-day access to therapists, which resulted in 2,945 sessions by 850 caregivers.

"One would imagine healthcare workers as somewhat more sophisticated consumers of healthcare than the rest of the population, and yet 46% of them said without this service they would not have sought help for themselves or would not have known how," Waghray said. "Like every other health system, we have had EAPs [employee assistance programs] and all of that forever, and yet this is something that has come up over and over again."

There is a kind of hero syndrome in healthcare that prevents some from showing vulnerability. During wellness checks, workers in the crowded Providence intensive care unit would always say they were doing fine, so Waghray reframed the question.

"We tried an exercise at the end of the day where they were asked what was something that made them smile that day, thus reframing the question to a positive light," he said. "I can say that is one of the richest experiences I've had. People were crying, they were talking a lot. The negative framing changed to positive."

For example, one nurse told a story about a patient who had been struggling and was trying to get out of bed, he said. The nurse helped him connect with a close relative, and he became relaxed and content.

Reinforce Rituals

Simplification and ritual have proved valuable in helping distressed healthcare workers at Geisinger Commonwealth School of Medicine in Scranton, PA.

"The donning and doffing of PPE is something that is automatic in many of us who work in healthcare institutions," said **Justin Coffey**, MD, chair of the department of psychiatry and behavioral health at Geisinger. "Maybe there is some way we can apply that ritual to our own psychological well-being."

To reinforce the program, healthcare workers were given different roles in addition to their regular jobs. These included tele-enablers, emergency department (ED) enablers, wellness rounders, peer supporters, communicators, and celebrators.

"Some of our frontline caregivers enabled a rapid shift to a 'virtual first' ambulatory [care]," Coffey said. "[The idea is] if we dedicated a small number of people to that role, they could do the learning and share that learning much more rapidly and effectively with a larger team."

ED enablers made sure incoming patients were triaged safely for staff and other patients. Clerical, financial, and office workers were the designated celebrators and communicators, publicizing the positive effects of the team effort. An outreach effort for remote staff emphasized social connection during physical distancing.

"The goal was to bring resilience to people rather than having to ask for it and seek it out," Coffey said. "We had some powerful interactions with those doing wellness rounds. We asked them a simple question: 'Are you OK?'"

Asked what he does to keep himself centered during difficult times, Coffey described a personal

ritual. "One of the things I do every morning is take a few minutes and ask myself, 'What is most important?' I spend my time on the answer to that question. The second thing that I do every day — at the end of the day — are meditation exercises to clear my mind so that when I go home I can be fully present. That is pretty ritualized donning and doffing for me. Different folks have different strategies, using exercise or social activities the same way they wash their hands one more time before they leave the facility." ■

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Caring for Our Caregivers Initiative Helps Healthcare Workers Meditate

Coronavirus triggers 'fight or flight' response

A nonprofit psychology group has launched the Caring for Our Caregivers initiative, distributing computer tablets with meditation and wellness exercises to help healthcare workers during the COVID-19 pandemic, according to **Saloumeh Bozorgzadeh**, PsyD, president of the Sufi Psychology Association, in Davis, CA.

The pandemic has exacerbated the longstanding issues of staff burnout in healthcare, adding elements of fear that may lead to post-traumatic stress disorder (PTSD), she says.

"Unlike burnout, which is this extreme mental and emotional exhaustion — on top of that you have this fear of not only your life, but your family can be affected by this if you pass something on to them," she says. "There is this profound fear. You don't really know what you're dealing with because COVID seems to manifest differently."

The prime mission of taking care of the patient can be threatened by this "incredibly strong" uncertainty, she adds. "You are in there as an expert who is supposed to fix people and know what to do. It is really frightening to think what these incredibly selfless people have had to go through."

Driven by donations and volunteers, Caring for Our Caregivers has distributed 491 tablets and 16,300 headsets to 151 hospitals to in the United States and globally. The tablets include Sufi meditation exercises and mental health apps that can be accessed when healthcare workers take a break. The headsets are disposable and the tablets can be wiped down between users.

Q&A

Hospital Employee Health asked Bozorgzadeh to comment further on the program in the following interview, which has been edited for length and clarity.

HEH: *Can you talk a little more how the tablets are used?*

Bozorgzadeh: This actually originated with the Sufi Psychology Association [SPA], a nonprofit organization that provides a lot of wellness for hospitals. We look at burnout and present workshops, meditation classes, and such. When COVID happened, we were already focused on burnout, and we knew the [coronavirus] had to be addressed right away. We have found from presenting wellness workshops at hospitals that one of the challenges is getting everybody together for a class. People have different schedules, they have patients that need them, so getting everyone together is challenging.

We tried to remove any barriers that will get in the way of these exercises. We didn't want to have wi-fi on these tablets or anyone logging in. They consist of visualization, deep breathing exercises, and meditative movements. We have six well-researched stress relief techniques such as guided imagery. There are about 12 videos on the tablets and range in time from about five minutes to 30 minutes.

HEH: *Where are these tablets typically placed?*

Bozorgzadeh: We catered to each hospital because the cultures are different. Some have wellness rooms, some have a chapel or a break room. We see what they have and we donate accordingly. Typically, it is a wellness room and we put in three tablets with a hundred disposable headsets. Three people can use them,

put back the tablets, and throw away the headphones. Some of the bigger hospitals might have more. One hospital created 11 nooks.

HEH: *Can you comment on the efficacy of this type of meditation?*

Bozorgzadeh: This form of meditation has been researched.[1-3] Previously, I was teaching it at a hospital in Chicago with cancer patients and the staff. It has been researched at Kaiser Permanente in California with heart patients. It's been taught as a course for years at the University of California, Berkeley. There was research done on the students there. It was really interesting because it showed that even though those students had higher stress levels than the average college population, their stress kept going down as they were practicing — even when they hit midterms and finals. It has been researched showing its effects on stress.

It has also been shown to increase positive emotions. Interestingly enough, it also increases people's daily spiritual experience on a scale that we use. What is fascinating about that is it didn't necessarily depend on someone's religious experience. Even people who identified as agnostic and atheist scored higher on that [spiritual] scale as well. Typically, in Western medicine, we focus on the biopsychosocial model of human beings. We think we are being holistic [saying], "psychology, biologically, socially they are healthy — great." But I thought this was interesting — someone experiencing spirituality even if they don't identify as having any kind of religious or spiritual practice.

HEH: *Can you tell us a little more about your experience with this program in medical settings?*

Bozorgzadeh: I was doing a resident wellness [program] at a hospital, presenting lectures on burnout and holding meditation classes to decrease stress for both oncology patients and staff at the hospital. We just finished [a program] at San Quentin (CA) State Prison Medical Center. They have a huge COVID issue right now. Our thoughts were of the healthcare workers and how stressed they must be. We created wellness rooms for the healthcare staff and put the tablets in there. In addition to that, we are creating an online wellness program to supplement what they already have in place. People need to be able to access these things on their own.

One thing I have found is that residents are required to attend the weekly meetings and workshops. The general staff are not. They have such widely varied schedules. We basically created an online platform with five- to 10-minute wellness videos from professionals from all over. These include how to manage anxiety, how to communicate better, and being more assertive and less aggressive. These are some of the workshops we have on these platforms for the staff whenever they have a moment. We are hoping that as people get more comfortable with the concept of meditation, we can ideally stream live sessions. Then, when things get better, perhaps go in person and do sessions.

HEH: *What are some of the tenets of Sufi meditation?*

Bozorgzadeh: Sufism is a spiritual practice and it's typically known as a mysticism of Islam. The goal of Sufism is that it is an individual journey for each person to know themselves. The way that is related to psychology is that when the SPA was formed, all of these practicing professionals saw that these teachings actually apply very well to the medical field. In psychology, a lot of what we feel — the anxiety and depression — stems from a lack of trust and knowledge of yourself. The more you have these experiential moments where you are tapping into the strength within, the more confident and powerful you feel, you can deal with life's ups and down much easier because you have something stable.

HEH: *What are you seeing in healthcare workers dealing with COVID-19?*

Bozorgzadeh: I have [counseling] clients who are nurses and physicians. One of my nurses was talking about going into a room and being given an N95 mask. She was already kind of nervous and said "Is this enough? They say that's all we have — it's enough." Then, a physician walks in in full [PPE] garb and she is feeling that she [does not have enough protection]. She worries about going home — [thinking] "Did I get it, too?" There is the whole thing about having to clean everything, undress before you go into the house, [worried] about infecting her family. She even suffers when she comes home, saying, "Please turn down the lights. I don't need any more stimulation."

It has heightened or sped up the whole burnout process. Typically, burnout happens slowly. You don't realize you are experiencing it — you are just kind of a little bit more irritable or annoyed with people. It kind of drags on before you actually burn out and you're showing a lot of symptoms. With COVID, you are going through it quickly, and because you are in crisis mode, your adrenaline is pumping. It's fight or flight. Everyone is just pushing through. When things quiet down, they recognize that there is something wrong with them.

HEH: *How does meditation address these issues?*

Bozorgzadeh: The research has shown it decreases your cortisol levels. It stimulates your autonomic nervous system because of the deep breathing techniques. It tells your body to relax. One of the more impressive things about meditation is that we are not really trained to navigate our brains. We know how our muscles work and how to strengthen them, but we don't really talk about our brains in this culture. A lot of us have wandering minds, going all over the place thinking about different things. It is hard to focus and concentrate. This is one of the things meditation does. You actually learn to direct your mind, quiet it down, focus it, which can be incredibly helpful if you are stressed and pulled in 20 different directions. If you're at home and relaxing, you can focus on just that and everything else can be put to the side. With burnout, what happens is that our mind is really adding a lot to the energy dispensed because we are thinking about different things. When you have anxiety, it is almost like a spiral you go down. It slows down that process and the feeling of your mind just racing. You can take control a little bit better. It also helps with reactivity because you are now becoming aware of thoughts and how they are affecting you. It builds a little bit of a gap between a stimulus and your reaction. You are not as reactive. ■

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Fear of Threats, Violence During Pandemic Response

Violence has been an ongoing threat to healthcare workers, but it is manifesting again as social tensions rise amid the COVID-19 pandemic. This became evident during the politicization of wearing face masks and threats against public health officials trying to enforce their use or mandate other pandemic control methods.

Pandemics historically have proven divisive, with certain groups scapegoated as the source of origin and spread. "But it doesn't have to be so mean-spirited, aggressive, and even violent. I think that is more a product of our times," says **Joshua M. Sharfstein**, MD, vice dean for public health practice and community engagement at Johns Hopkins Bloomberg School of Public Health.

Sharfstein and colleagues recently wrote an editorial outlining the situation. "The present harassment of health officials for proposing or taking steps to protect communities from COVID-19 is extraordinary in its scope and nature, use of social media, and danger to the ongoing pandemic response," the authors noted. "It reflects misunderstanding of the pandemic, biases in human risk perception, and a general decline in public civility. Some of these causes resist easy fixes, but elected officials and health officials can take certain actions to help address the problem."[1]

To some degree, the antivaccine movement that has undermined

childhood vaccinations for years has expanded to be anti-public health in general. "There is a lot of crossover," Sharfstein explains. "There are a lot of people who are active against vaccines who now are active against masks. There are conspiracy theories about flu vaccinations, and [false fears] have led to measles outbreaks. If they don't vaccinate against flu, it increases the chance of dying of flu. Now, we have a pandemic."

Across the United States, private information of health officials has been revealed for the purposes of harassment, protesters showing up at their homes, and threats warranting private security personnel. "I think it is very important that public officials support health officials — and, when necessary, it's important to protect them," Sharfstein says.

The pandemic is a global outbreak and clearly causes death and disease, but there are several reasons people may be blind to personal risk. The ability to perceive such harms can be undermined by decisional biases known to affect human thinking. A contributing factor is "omission bias," which is a preference for risks associated with doing nothing over those linked to following public health orders, Sharfstein explains.

"Distance bias and optimism bias may be operating for those who believe COVID-19 will not seriously affect them or their loved ones," the authors noted. "In an information space flooded with conflicting information, confirmation bias allows some people to dismiss evidence that does not comport with their pre-existing beliefs."

Such beliefs can be expressed on social media and in attack campaigns against public health experts like Anthony Fauci, MD, director of the National Institute for Allergy and Infectious Diseases.

"The environment deteriorates further when elected leaders attack their own public health officials," Sharfstein and colleagues noted. "Members of the current presidential administration, and various members of Congress, have displayed hostility toward experts inside and outside of government. … Instead of attacking their health officials, elected leaders should provide them with protection from illegal harassment, assault, and violence."

Thus far, violence against hospital workers related to the pandemic has not been reported widely.

"Anecdotally, on emergency department violence, there have been some incidents," says **Steven Arnoff**, spokesman for the American College of Emergency Physicians. "For example, confrontations with patients' family upset about visitation restrictions."

Are Laws the Answer?

Although many states are requiring masks in public settings, others are not, and there are varying degrees of enforcement across the board. A national law could be more effective in ensuring compliance with this key measure against viral spread, but would likely face states' rights legal challenges, says **Lawrence O. Gostin**, JD, faculty director of the O'Neill Institute for National and Global Health Law at Georgetown University in Washington, DC. For now, laws by states may be more effective. Over time, such laws typically become more accepted, he notes.

"Laws not only require people to engage in healthy behavior, but also can change personal beliefs and practices over time," Gostin says. "Even if a law is initially controversial, often it ingrains behavior in the population. A good example is seat belts. Seat belt laws were controversial when first implemented, but the public came to regard the use of seat belts as just common sense. I see mask mandates working in the same way."

Gostin recently co-authored an article looking at the mask issue and the role of the Centers for Disease Control and Prevention (CDC) during the pandemic.

"Historically, states and localities have assured the public's health, with the CDC providing funding, technical guidance, and coordination," the authors reported. "National coordination is achieved as states adopt evidence-based recommendations from the CDC. This model, however, breaks down if the federal government does not consistently support the CDC and the science undergirding its guidelines."[2]

Among the lessons of COVID-19 is that the CDC should be better insulated from political influence and given greater autonomy in responding to a public health crisis while "preserving the integrity of science," Gostin and colleagues wrote. Funding sources should come from Congress.

"The CDC was marginalized because the president and the White House contradicted CDC's science-based advice and even refused to allow CDC to issue certain guidelines, like school opening guidelines," Gostin tells *Hospital Employee Health*. "We need to return to a political landscape where political officials support science and key public health agencies like CDC. COVID shows that we need national, uniform legal standards, and CDC is best positioned to use science as the basis for new powers." ■

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Pandemic Coronavirus May Kill the Handshake

Some level of microbe transfer with fist bumps as well

The COVID-19 pandemic may be the death knell of the handshake, although its deep anthropological roots may resurface after the viral storm is over.

The handshake is an ancient custom, with its origins thought to be a sign that one was unarmed in greeting another. With the suggestion that it originated with the opening tap of gloves in boxing, the fist bump is generally considered the hipper and less contagious version of the handshake.

The elbow bump has become the pandemic equivalent of touching fists, but these and other social gestures that bring people in close proximity are all being rethought as SARS-CoV-2 spreads globally.

Fist Bumps May Transmit Virus

A study using nonpathogenic bacteriophage MS2 as a viral surrogate found that handshakes and, to a lesser extent, fist bumps can be sources of transmission.[1] Another study by the same clinical group found that both greetings also could transmit methicillin-resistant *Staphylococcus aureus* (MRSA).[2]

Curtis Donskey, MD, an infectious disease physician at Louis Stokes Cleveland VA Medical Center, led the research.

"In both studies, the bottom line is that any sort of greeting that involves contact between hands seemed to be very efficient at spreading viruses or MRSA," he says. "Even though the fist bump was statistically better than the handshake, with a little bit lower transfer, there was still plenty of transfer. You definitely wouldn't want to do a fist bump with a COVID patient."

In the viral study, 22 participants used a keyboard and mouse contaminated with MS2 for two minutes, then shook hands and fist-bumped in randomly assigned order with 22 noncontaminated participants. "After use of the contaminated keyboard and mouse, the fist bump greeting resulted in significantly less frequent transfer of bacteriophage MS2 and in fewer viral particles transferred than the handshake," the authors found. "However, the frequency of viral transfer with the fist bump was strikingly high despite the reduced surface area of contact involving only the back of the hand."

The findings suggest that viral particles on the fingers and palms may be transferred rapidly to the back of the hands.

No Handshakes Is 'New Normal'

In the other study, 50 MRSA-colonized patients participated in hand greetings with researchers wearing sterile gloves. The contact portions of the sterile glove were cultured, and the number of MRSA colony-forming units were tabulated. Again, there was a reduction in the frequency of MRSA transfer for the fist bump (16%) vs. the handshake (22%). Although less, the level of contamination with the fist bump still was a concern.

"Our data would suggest that in the setting of COVID or even MRSA, [the fist bump] is probably not a good idea," Donskey says. "The hands are a tremendously efficient way to transfer viruses or bacteria, and even hand hygiene isn't perfect at eliminating contamination. I think as much as possible I would avoid hand-contact greetings." That is another "new normal" of the pandemic, but it remains to be seen whether the entrenched practice of handshakes will return.

"There is a pretty significant cultural change occurring in the community and in the healthcare setting," he says. "[Handshaking] is kind of hard to break, but it is happening now." ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **In a statement following controversial COVID-19 testing recommendations, Centers for Disease Control and Prevention (CDC) Director Robert Redfield, MD, said:**

   a. testing contacts of a confirmed case is unnecessary due to the high proportion of false-negatives.
   b. testing may be considered for all close contacts of confirmed or probable COVID-19 patients.
   c. contacts not tested should wear a mask but need not social distance.
   d. those who test positive but are asymptomatic should be retested immediately.

2. **What did Anthony Fauci, MD, say about the revised testing guidelines?**

   a. He argued against the revisions, but was overruled.
   b. He said they did not go far enough in scaling back testing for SARS-CoV-2.
   c. He worried they will give people the incorrect assumption that asymptomatic spread is not of great concern.
   d. He praised the CDC for taking such bold action.

3. **Arpan Waghray, MD, tried a different approach in assessing wellness of healthcare workers by asking:**

   a. "What did you make lemonade out of today?"
   b. "What did a patient say to you today in support of your efforts?"
   c. "Where would you like to travel once the pandemic is over?"
   d. "What made you smile today?"

4. **Which federal agency did Lawrence O. Gostin, JD, of Georgetown University, say should be better insulated from political influence and given greater autonomy in responding to a public health crisis while preserving the integrity of science?**

   a. Food and Drug Administration
   b. CDC
   c. Occupational Safety and Health Administration
   d. Department of Health and Human Services