RISE and Shine: How Jefferson Health's Peer Support Program Improves Care for All

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Evidence suggests that providing psychological support to caregivers can make care safer. Such is the basis for Jefferson Health's RISE program: peer-to-peer mentoring for providers involved in patient harm. Program leads, ***John Olsen*** *and* ***Dr. Scott Cowan****, sat down with* Patient Safety *managing editor,* ***Caitlyn Allen****, to discuss the program's genesis, the positive impact it's had on staff, and how the program can be replicated in other institutions.*

Caitlyn Allen: John, tell me about the RISE program.

John Olsen: RISE stands for Resilience in Stressful Events, and it's a psychological first-aid, peer support team for distressed healthcare workers and providers. Based on the Johns Hopkins and The National Child Traumatic Stress Network models, RISE incorporates trained responders from various roles who offer peer support in the immediate wake of a stressful or traumatic workplace event. This may include events such as death or code, loss of a child or infant, workplace violence, medical error, or other adverse events. Since the implementation of the RISE program across the Jefferson Health enterprise, more than 400 healthcare staff and providers have received peer support that has helped them return to resiliency following a distressing event.

CA: What led the team to think there was a need for it?

JO: Prior to the initiation of the RISE program, traumatic workplace events often left providers and staff feeling isolated and unable to adequately cope. This resulted in a significant emotional or psychological impact on these employees. In some cases, we could refer affected staff to the Employee Assistance Program (EAP) or offer other services through human resources or psychiatry, but we did not have a dedicated peer support program in place.

In 2014, two nursing leaders, Danielle Giovanniello and Lisa Kirby, noticed the need for a peer support program for distressed healthcare workers. They formed a steering committee, researched best practices, and conducted an in-depth literature review. I came on board as the program manager in 2017, and we went live with the program hospitalwide in the spring of 2018.

As a chaplain, I participated in many calls involving distressed staff over the years. Initially, we had more of an informal approach, where we would piece together the EAP and coordinate with leadership to offer supportive services. Before RISE, we did not have a dedicated peer support team that could respond in the immediate wake of a traumatic adverse event. Since the inception of the RISE program at Jefferson Abington Hospital in 2017, more than 100 distressed healthcare staff and providers have received peer support that has helped them return to resiliency following such events.

CA: John, while you were instrumental in getting this off the ground at Abington, Dr. Cowan, your role was really to take this and then implement it enterprisewide.

Scott Cowan: Two of our senior leaders had worked in a hospital system outside of Jefferson and implemented a program that provided psychological first aid. They loved the concept and how the program evolved at their institution, and they asked that a similar program be implemented at all our Jefferson Health hospitals. We were fortunate to learn that John and his team had a successful program that was already up and running.

We started to expand the program across the Jefferson Health enterprise in September 2020. We began by creating local and enterprise steering committees to oversee the implementation of the program in all our hospitals. Within three years, 17 of our 18 hospitals are now live with a RISE peer support program.

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CA: That's incredible. When you mentioned that you began to roll this out in September 2020, how much of an impact did COVID-19 have on that decision?

SC: We started the expansion of the RISE program in the middle of the pandemic. At first, we were concerned with how stretched our frontline providers were and what they were going through. Would they have the time and the energy to do something like this, and should we be pushing this forward right now? We were so glad to see the overwhelming response from our colleagues who signed up to be trained and helped. In retrospect, it couldn't have started at a better time.

JO: When the COVID-19 pandemic hit, the Abington RISE program was in place and already well utilized. While no one could have foreseen the scope and impact of the pandemic, we had an effective peer support program to help meet the need for emotional support. Initially, some providers and staff feared COVID exposure. During the pandemic, we also had many people, understandably, who were deeply affected emotionally by what they witnessed as providers. Our team of responders rose to the need and offered timely peer sessions with the support of management and senior leadership. In the early weeks of the pandemic, one of my colleagues, the Abington psychiatry chair, Dr. Diane Custer, developed the Proactive Support Team, through which healthcare staff rounded on units throughout the hospital.

CA: Tell me more about the Proactive Support Team.

JO: The Proactive Support Team involves rounding by staff volunteers on nursing, units, and other support departments several times a week. Volunteers go in pairs to provide hospitality, positive psychology, and a listening ear to the staff at the unit level. Rather than waiting for staff to come to us, we meet the healthcare teams where they are. Several RISE team members participate and as needed, make referrals for additional support.

Traditionally, RISE was designed as more of a responsive service in the immediate wake of an event in that one-to-24-hour period. The Proactive Support Team complements that approach by going to the units that are stressed and affected, and providing moral support and those resources.

SC: We've expanded upon the great proactive rounding process that John and his team created by reaching out to individuals who are involved in events that are challenging. We call this approach a "soft touch," which consists of a brief phone call and a discussion about available coping resources if needed. If they need a referral to another resource, or if they want to undergo a formal RISE session, we offer our own support and other support available within our hospitals to help them through this difficult time. Of the 400 encounters that have occurred across the enterprise, the majority involved a proactive reach-out.

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CA: Healthcare workers have a reputation for not taking great care of themselves. Their focus is taking care of patients. With that, have you found any challenges trying to implement this throughout the enterprise?

SC: A RISE hotline is in place at all our hospitals where support is available 24/7. Employees can call a number and have immediate access to a peer. We receive, on average, between two to four phone calls a month through that line. It is difficult for caregivers to reach out and ask for help so the team has developed a proactive approach. This tactic is based on published literature from experts in psychological first aid who have built peer support programs for distressed healthcare workers at other institutions.

CA: What tactics have you taken to try and overcome any initial hesitation?

JO: When we started RISE at Abington, we did a lot of recruitment and promotion to raise awareness. In-servicing with new employees and residents, both medical and nursing, is also offered. These opportunities help to develop a sense of trust. As the program has grown, staff who received help and had a positive experience have shared that with others. We do not actively gather feedback from the recipients due to confidentiality. To maintain trust with providers and staff, the program is completely confidential, and we relate on a peer-to-peer, first-name basis.

We have also encountered some barriers to implementation. Some medical providers were initially somewhat reluctant to use the program. However, through word-of-mouth an increased awareness of the program occurred; not only have these providers participated, but many have also joined our team. This has built interprofessional trust and connections. Our Abington team includes a wide variety of roles, from our administrative quality associates to a senior vice president of the hospital, with many nurses and social workers, and me as a chaplain.

CA: You mentioned two nursing leaders who initially started the program at Abington. How did it expand to include such a diversity of roles?

JO: They searched best practices, visited some other programs in the region, and developed a steering committee with key stakeholders from several departments, such as medical leadership, nursing leadership, social work, legal, security, and even our communication staff. By getting those core constituencies involved and invested from the start in our steering committee, they spread the word to their departments and colleagues, and helped raise awareness about using the program.

CA: One of our goals for conducting interviews with experts in the field is to provide a roadmap for others to implement successful programs in their institutions. What other advice besides having a multidisciplinary approach would you offer to somebody if they want to implement a RISE program at their hospital?

SC: There are a lot of great programs that you can use as a model. Johns Hopkins University hospitals have an excellent program; the University of Missouri has a wonderful program. We found the Hopkins program worked not only at Abington but also across all Jefferson Health hospitals. The goal is always the same: to provide peer support. Sometimes you have to modify operations and workflows in the individual hospitals instead of trying to force a cookie-cutter approach.

CA: So, not trying to force a square peg into the round hole?

SC: Exactly.

JO: Psychological first aid by its very nature is a toolkit approach. We provide several resources for our responders that they can readily use and adapt in a variety of situations. Our trainer, Steve Crimando, is masterful with what has been described as an "every person" approach in which responders from all roles can be part of the team.

In other words, a volunteer doesn't need to be a trained psychiatric nurse or crisis responder. People from a variety of roles and walks of life in the healthcare community can help. That makes this program replicable, cost-effective, and able to be readily implemented at a variety of organizations.

SC: Leadership support at each of the hospitals has been critical for the program's success. Strong local RISE leads are also critically important to the success of the program. John has an amazing team at Abington. There are typically two individuals who serve as leads at each of our hospitals and are dedicated to supporting their peers through difficult times. All our enterprise hospitals have exceptional leaders who are truly dedicated to the well-being of their colleagues.

CA: Has anyone you've known ever participated in a medical error and if so, can you walk me through what that feels like from the clinician's perspective?

SC: It's challenging, and these errors can be incredibly difficult to process. Even though we are all trying to do our best for the patient, we are all human, and errors occur. We try to do everything we can to eliminate the potential for errors by improving our systems, but we can never eliminate them completely. There has been a positive response from people involved in medical errors, and sometimes these providers and staff members do need further support. We help them connect with their EAP or psychiatry if necessary.

CA: Has the RISE program impacted interactions between patients and clinicians and if so, how?

SC: We know that these adverse events can impact our providers and subsequently may have an impact on patient care. Moving on from that can be a challenge. There is evidence in the literature that peer support programs can help individuals cope with traumatic healthcare events. There is also some evidence that psychological first aid may help mitigate or prevent medical errors or other issues that occur while the caregiver is trying to cope with this event emotionally and psychologically.

JO: Absolutely, and staff know they can call the RISE team for support when they have a stressful or traumatic encounter with a patient or family. While we don't ask for feedback directly for confidentiality reasons, we have heard anecdotally from several providers that it's been helpful in the wake of such overwhelming events.

Fortunately, there's a growing body of evidence in the literature that initiating such sessions in the immediate wake of an event can be helpful. Sessions contribute to staff resilience in the long term and achieve significant cost savings for the organization by helping to prevent burnout and attrition.

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CA: What's next for the RISE program?

JO: We are continuing to expand our reach, and we're in discussion with the one remaining hospital within the system that has not yet gone live with RISE. We plan to bring them on board in early 2023. We also want to look for ways that these skills can be shared more broadly, both within the medical community and the community at large.

We would like to thank all the leaders and volunteers who participate in the Jefferson Health RISE program. It is a privilege to work with this amazing group of caring and dedicated individuals.

If anyone is considering starting a peer support program, please feel free to reach out, and we would be glad to meet to discuss the evolution of our program.

Thank you, Caitlyn, for the kind invitation to discuss the Jefferson RISE program.

About the Authors

John Olsen (john.olsen@jefferson.edu) is a chaplain at Jefferson Abington Hospital, where he also manages Resilience in Stressful Events (RISE), a peer support team for distressed healthcare workers, which launched in 2018. Since the COVID-19 pandemic, he has worked closely with other staff wellness leaders to implement the RISE program throughout the Jefferson Health enterprise. The Rev. Olsen has an abiding commitment to building stronger communities through caring for the caregiver; in addition to his roles at Jefferson, he facilitates a bereavement support group for community members and has participated as a guest panelist in the Schwartz Rounds and seminars on clergy wellness.

Scott Cowan (scott.cowan@jefferson.edu) is the medical director for Enterprise Risk, interim chief quality officer for Jefferson Health, and the Jefferson enterprise lead for Surgery Quality and Safety. He received his doctor of medicine degree at Thomas Jefferson Medical College in 1997 and then completed a seven-year surgery residency at Thomas Jefferson University Hospital. Dr. Cowan completed his cardiothoracic surgery fellowship at Massachusetts General Hospital in 2007 and worked for three years in the University of Pennsylvania Health System as a general thoracic surgeon. He has been a faculty member at Thomas Jefferson Health system for over 10 years and holds the rank of associate professor of Surgery. Dr. Cowan is a frequent speaker and has more than 70 peer-reviewed publications in surgery and quality and safety–related journals.

Caitlyn Allen is director of Engagement for the Patient Safety Authority and managing editor for *Patient Safety*, the PSA's peer-reviewed journal. Before joining the PSA, she was the project manager for Patient Safety at Jefferson Health, where she also was the only nonphysician elected to serve on the House Staff Quality and Safety Leadership Council. Previously, Allen also was a project manager and patient safety officer for Wills Eye Hospital.