

Suicide Prevention

Evidence-Informed Interventions for the Health Care Workforce

Analysis of Interviews and Focus
Groups on Supporting Mental
Well-Being & Suicide Prevention
among Health Care Workers

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Background

The American Hospital Association (AHA) conducted a series of one-on-one interviews and focus groups to gather more in-depth information about the responses and findings from the final and revised surveys, conducted from November to December 2021. Interviews and focus groups were conducted between March and April 2022 to learn more about suicide prevention programs that hospitals and systems are implementing to support the mental well-being of their staff, as well as the challenges and barriers encountered in these areas. The interviews and focus groups consisted of staff from the identified hospitals and health systems, and focused on organization-specific programs, peer-to-peer support group implementation, and Employee Assistance Program (EAP) resources. Because the participating sample is small and not necessarily representative, the findings from these individual and group interviews are not generalizable to all hospitals and systems. Refer to Appendix 3 for interview and focus group protocols.

Sample and Methods

Interview and Focus Group Selection Criteria

Eight hospitals and systems participated in one-on-one interviews detailing their organizational programs tailored to expanding mental health services and preventing suicide in their healthcare workforce, five hospitals and systems participated in the peer-to-peer support focus groups, and three hospitals and systems participated in the EAP focus group. Selected based on their survey responses to specific questions and their willingness and availability, hospitals and systems were to provide additional context via an interview/focus group process. Tables 1 and 2 summarize the reason each hospital or system selection.

¹ Two surveys were conducted to identify programs that hospitals and systems are implementing to support the mental well-being of and prevent suicide among health care workers, as well as the challenges and barriers encountered in these areas. The initial survey (conducted from October to November 2021) had six responses, and the final (or revised) survey (conducted from November to December 2021) had 158 responses. Excluding demographic questions, the initial survey had five questions and the final survey had seven. A quantitative analysis was conducted to sum counts and percentages to yes/no and “check all that apply questions.” A qualitative analysis was conducted to gather themes from the open-ended questions and the “other” options in the “check all that apply” questions. Key findings from the final survey analysis bolster this report.

Table 1. Hospital and Systems Selection Reasons for Interviews

Hospital Name	Location	Interviewee Role(s)	Reason Selected for Interview
Boston Medical Center	Boston, MA	<ul style="list-style-type: none"> • Chief Executive Officer • Employee Assistance Clinician 	Applied a Diversity, Equity, and Inclusivity/ Social Determinants of Health (DEI/SDOH) approach to suicide prevention
CHI Health	Omaha, NE	<ul style="list-style-type: none"> • Organizational Resilience Coordinator • Vice President, Behavioral Health Services • Director of Quality 	Used a tiered program of care that provided resources for their employees.
Hackensack Meridian Health; Hackensack University Medical Center	Hackensack, NJ	<ul style="list-style-type: none"> • Chief Wellness Officer 	Created a behavioral health navigation program so that there is only one number to call. Provided an acute, 24/7 crisis management line; the line services to navigate team members to longer-term resources.
Hartford HealthCare	Hartford, CT	<ul style="list-style-type: none"> • Director, Well-being Board Certified in Clinical Health Psychology • Vice President, Chief Wellness Officer & Associate Chief Medical Officer 	Focused on a system of well-being efforts including 1) measurably improving well-being for all, 2) creating innovative well-being solutions and 3) becoming a thought leader internally and externally through research, training, and education.
MetroHealth Medical Center	Cleveland, OH	<ul style="list-style-type: none"> • Senior Vice President, Chief Equity Officer 	Developed a DEI/SDOH approach to suicide prevention
Oregon Health and Science University	Portland, OR	<ul style="list-style-type: none"> • Director, Wellness Consults for Leaders and Teams, Covid-19 Wellness Task Force • Associate Director, Resident and Faculty Wellness Program 	Developed by their Covid-19 Wellness Task Force, Wellness Consults for leaders and teams has led to mental health professionals providing in-house psychological support and guidance to many healthcare team leaders.
Thomas Jefferson University & Jefferson Health	Philadelphia, PA	<ul style="list-style-type: none"> • Manager, Employee Emotional Health Resources 	Built individual, group, and team-based interventions to support frontline colleagues as they faced risk of exposure, large numbers of patient deaths, and deaths of loved ones. The Department of Psychiatry and Human Behavior and Human Resources launched a 4-tiered pyramid of mental health offerings for health care workers.
Trinity Health	Minot, ND	<ul style="list-style-type: none"> • Administrative Director of Behavioral Health 	Utilized a Mental Health Advocate full-time rounding at the hospital with all staff.

Table 2. Hospital and System Focus Groups Topics

Focus Group Topic	Hospital Name	Location	Interviewee Role(s)
Peer to Peer Support/ Care for the Caregiver/ Second Victim Support	Atrium Health Cabarrus	Concord, NC	Adjunct Faculty, Wake Forest School of Medicine Nurse Anesthesia Program & Atrium CARE Peer Support Program Leader
	JPS Health Network	Fort Worth, TX	Director, Inter-professional Well-being
	Lakeland Regional Health	Lakeland, FL	Associate Vice President, Behavioral Health
	SSM Health	St. Louis, MO	System Medical Director, Healthy Work & Well-being
	St. Luke’s Hospital	Kansas City, MO	Director, Risk and Operations Director, Behavioral Health Service Line
Employee Assistance Program (EAP)	Bryan Health	Lincoln, NE	Director, Behavioral Health
	Henry Ford Health System	Detroit, MI	Chief Clinical Wellness Officer
	Mercy Health System	St. Louis, MO	Licensed Clinical Social Worker

Methods

Interview and Focus Group Data Synthesis

The American Hospital Association (AHA) staff facilitated the interviews and focus groups using a defined protocol as a guide, and captured detailed notes. Each sessions was recorded and transcribed using Microsoft Teams software, which were then synthesized. Interviews with individual hospitals and systems were 45-minute sessions and focus group with multiple hospitals and systems were 90 minute-sessions. Due to the conversational nature of the interviews and focus groups, some questions from the interview and focus protocols remained unanswered (refer to Appendix 3 for interview and focus group protocols).

Qualitative Analysis Methods

A deductive analytic approach was used for analyzing the interview data. The deductive approach used preselected themes based on the final survey results. Expanding Access to Mental Health Services for Healthcare Workers, Destigmatizing Mental Health Services Utilization and Mental Health Wellness, and Increasing Job Support for Healthcare Workers. Other generalizable, yet pertinent themes or key pieces of information specific to a hospital or system are to be included in Appendix 1, Hospitals and Systems Quotes.

An inductive analytical approach was used for analyzing the focus group data, more specifically conducting a thematic content analysis. There was no preselected theme established before analyzing the focus groups due to the focus groups’ conversational nature. Rather than each hospital or system responding to each focus group question, different interviewees organically generated questions for their peers garnering more overarching themes as a collective focus group. Other generalizable, yet pertinent themes pieces of information and resources specific to a hospital or system are included in Appendices 1 and 2.

The steps used in analyzing the interviews and focus groups were:

1. Listening to recordings and reading the transcriptions multiple times. First for the fit of preselected themes and identifying potential emergent topics, then finalize the summarization of themes.
2. Compiling the relevant findings (based on the deductive and inductive analytical approach mentioned above) into an excel spreadsheet by interviews or focus groups, by hospital, and was then organized by preselected or emergent themes.
3. Annotating the recording and transcription notes, assigning preselected themes, or identifying emergent topics including a short sentence to summarize the finding.
4. Sorting and segmenting the themes into finalized/formed buckets of preselected themes and emergent topics by hospital or system.
5. Analyzing and summarizing findings, determining if themes were more prevalent within the hospitals or systems and how the findings align with the final survey results.

Qualitative Analysis Findings

Note on Interview and Focus Group Findings

Interviews with eight hospitals and systems and two focus groups with eight hospitals were conducted to identify programs and resources that hospitals and systems are implementing to support the mental well-being of and prevent suicide among health care workers. Based on the interview and focus group responses, conclusions and key findings are drawn below, specifically in the areas of increasing access to mental health services, destigmatizing mental health issues, supporting healthcare workers on the job, and additional emergent topics.

Limitations

The AHA conducted a targeted outreach to hospitals and systems based on their responses to the final survey. Because the interviewees for both individual interviews and focus groups were selected based on their final survey responses, the responses and topics from the interviews and focus groups may not necessarily be representative of all U.S. hospitals and systems. Hence, these conclusions are not necessarily generalizable beyond the interviewing sample.

Brief Summary of Findings

- Impactful programs have resources and services available that healthcare workers feel comfortable and empowered to utilize, especially in times of crisis. Healthcare workers access more services when multiple options to pursuing mental health services (onand offsite care) and wellbeing resources are provided while also ensuring private and anonymous care (Interview Key Findings, Section A. Increasing Access to Mental Health Services).
- Equipping healthcare workers with adequate mental health trainings, like Mental Health First Aid and Psychological First Aid, and promoting mental health awareness campaigns reduces the stigma of care-seeking behaviors, creates a culture of advocacy for treating mental health issues and suicide prevention (Interview Key Findings, Section B. Destigmatizing Mental Health Issues).
- The best assets are people, successful programs come from dedicated staff and leadership (Interview Key Findings, Section C. Supporting Healthcare Workers on the Job)
- Peer support groups are powerful platforms for healthcare worker wellbeing that are possible to do in any hospital setting.

- Leadership and dedicated staff focused on the mental health and wellbeing of healthcare workers must be a part of establishing and modeling a culture that acknowledges and addresses the mental stressors of the healthcare workforce, promotes resiliency, and creates targeted programs and policies that meet the needs of their workforce.
- Collecting data on healthcare worker engagement, satisfaction, and utilization of services creates tailored and effective programs for supporting mental wellbeing and suicide prevention (Focus Group Key Findings, Section A. Peer-to-Peer Support Focus Groups)
- When creating programs, start with understanding healthcare workers' needs with employee needs assessments.
- Continually monitor utilization and impact of current programs with healthcare worker satisfaction and engagement surveys.
- Creatively advertise available mental health services and wellbeing resources continuously, personally, and ubiquitously through apps, intranet portals, and word-of-mouth (Focus Group Key Findings, Section B. Employee Assistance Program (EAP) Focus Groups)
- Most notably, some hospitals' social workers and other mental health workers provided snacks to healthcare workers on the floor to gain more visibility to the EAP services offered and establish rapport.

Interview Key Findings

Within the areas of increasing access to mental health services, destigmatizing mental health issues, supporting healthcare workers on the job, and additional information, sub-themes emerged across multiple hospitals and systems supporting mental wellbeing and preventing healthcare worker suicide. This section highlights the present challenges experienced and the solutions the interviewed hospitals and systems have implemented.

A. Increasing Access to Mental Health Services

1. Providing anonymous and private access to mental health services, ensuring offsite and onsite care mental health services availability depending on the needs of the healthcare workers

Present Challenges

In the final survey, survey respondents stated not having enough time to access services. However, another large barrier to accessing mental health services was ensuring that the healthcare workers' anonymity and privacy are intact. Healthcare workers prefer to have offsite care, which reduces the stigma barrier. Moreover, if providing onsite care, then protecting healthcare workers information from their supervisors and peers is priority.

Solutions

- Interviewed hospitals and systems noted that providing onsite mental health services combated the limited time barrier to accessing mental health services. A strategy on providing enough time to access services is conducting mental health services onsite. Multiple hospitals and systems consistently stated that providing access to mental health services in a way that honors and is most accessible to the healthcare worker makes it far more likely that healthcare workers will utilize mental health services (refer to Appendix 1, CHI Health Quotes for more details on providing accessible mental health services to their healthcare workers).
- Some solutions to anonymous and private care include, separate and de-identified electronic health records (EHR)-especially if the hospital is self-insured; partnering with other local hospitals and behavioral health centers to refer healthcare workers to reliable offsite care; if onsite care, staggering the appointment times to ensure no overlap or chance of encountering fellow healthcare workers.

- The most effective approach is layered services, allowing healthcare workers to have a choice to pursue on or offsite care and ensuring and promoting anonymity and privacy.

1. Compiling mental health services and resources that are clearly visible and accessible for self-help, and providing 24/7, wrap around services informational hotlines that all staff can use

Present Challenges

Almost all 158 hospitals and systems (99%) within the final survey stated the use of an Employee Assistance Program (EAP) to support their healthcare workforce. Traditional, EAPs act as the “one stop shop” for all supporting resources for healthcare workers (Final Survey, Questions 1 and 3). Hospitals and systems interviewed noted that the traditional EAP was underutilized and did not meet the needs of their healthcare workers.

Solutions

- Multiple hospitals and systems noted their EAP expansion allowed for more healthcare workers to access services more readily. Many interviewees compiled a list of vetted mental health services and resources into one place on the hospital intranet that their healthcare workers could easily see every day. This allowed for a self-help approach for those that did not require intensive services and lowered the barrier to entry searching for applicable resources (giving healthcare workers a place to start with seeking mental health services).
- Other strategies were to provide 24/7 access to hotlines and help desks for healthcare workers, noting that healthcare work is 24/7, so resources should be available 24/7 as well. Some hospitals noted the all-day access to onsite services staffed by hospital nurses and mental health professionals in case staff need immediate and onsite care.
- The expansion of the EAP was to act as a bridge to longer-term services because there was realization that healthcare workers might not have the time to find longer-term care without guidance and referrals. This reduces the barriers healthcare workers can face when needing a range of services—self-help resources, immediate help, and longer-term mental health care.
 - Hospitals and systems utilized virtual therapy companies like Marvin and Orexo (see Appendix 2 for more details on Marvin and Orexo therapy services)
- The comprehensive hotlines and list of resources has proved beneficial for the interviewed hospitals and systems, by allowing healthcare workers to connect easily to other programs and initiatives in the hospital to support healthcare worker mental wellbeing and suicide prevention.

2. Employing dedicated mental health staff for healthcare workers

Present Challenges

Creating an infrastructure of programs and personnel dedicated to healthcare worker wellbeing is an observed challenge from the final survey; interviewed hospitals and systems created job positions that support healthcare workers successfully.

Solutions

- An effective strategy noted multiple times was to employ dedicated mental health staff for healthcare workers. Some hospitals noted hiring social workers, clinical therapists, and resilience coordinators while also utilizing existing positions in the hospital to support their healthcare workers. Refer to Appendix 2 for a sample job description for a Mental Health Advocate at Trinity Health.
- The dedicated staff get to know the healthcare workers on a deeper level and establish trust to discuss mental health issues and pursue mental health services; the dedicated staff get to know the healthcare workers by being on the job with them, seeing the stressors, and understanding the work environment. This is a powerful asset for hospitals and systems because healthcare workers access care in real time, and this model allows the dedicated staff to tailor their support to an individual, team, or the organization.

- Dedicated mental health professionals onsite and available to healthcare workers specifically was noted as being like a personified EAP walking around the units focus solely on the support and success of their healthcare professionals (see Appendix 1, Boston Medical Center Quotes for more details on their utilization of social workers support healthcare workers).

B. Destigmatizing Mental Health Issues

1. Increasing mental health awareness through various trainings like mental health first aid, psychological first aid, stress first aid, etc., and participating in national initiatives like the Zero Suicide Program decreases the stigma around care-seeking behaviors

Present Challenges

Creating a culture that destigmatizes accessing mental health issues is a barrier multiple interviewed hospitals faced when creating programs and resources. Noted in the final survey findings, psychological safety training and mental health education and resources created or increased a broader sense of psychological safety amongst health care workers (Final Survey, Questions 4 and 5). Multiple hospitals and systems in their interviews expressed that having healthcare workers participate in mental health education and training increased awareness of mental health issues especially pertaining to the demands of healthcare workers.

Solutions

- The healthcare workers trained on how to support their peers in times of crisis as well as fostering a supportive environment at work when peers are struggling. Mental Health First Aid, Psychological First Aid, Stress First Aid, QPR (Question, Persuade, Refer) trainings are listed programs hospitals and systems utilized to increase mental health literacy and create a culture that destigmatizes mental health issues and preventing suicides. Interviewed hospitals and systems stated their healthcare workers were more aware of mental health issues felt more equipped to support their peers.
- In some hospitals, trainings were not just for the clinicians, it was also for the hospital leadership to ensure that the positive culture changes were organization-wide (refer to Appendix 1, Hackensack Meridian Health Quotes see more details on their mental health training for leadership).
- The Zero Suicide Program continues being beneficial in providing a framework for how hospitals and systems can support healthcare workers and destigmatize accessing mental health services. Zero Suicide Program teaches clinicians about suicide prevention, creates a culture committed to reducing suicides in healthcare workers, and fosters a more empathetic workforce (refer to Appendix 2 for more details on the Zero Suicide Program).

2. Creating a culture of open communication around mental health status fosters successful programming

Present Challenges

Interviewed hospitals and systems noted that the core of successful program implementation comes from creating buy-in and a culture of open communication around difficult conversations. Interviewed hospitals and systems stated there must be acknowledgement that everyone struggles, especially during the COVID pandemic, to address the stigma of accessing mental health support and services. The interviewed hospital and systems creatively tackled the stigma around mental health issues in their organizations.

Solutions

- Thomas Jefferson University & Jefferson Health conducted a “Secrets Day” where all medical students and residents wrote down their secrets of what they were struggling with mentally. The results from their compiled secrets showed there were common issues that all healthcare workers struggled with, and when sharing the results, resources were allocated to suit the needs of the medical students, residents, and other healthcare workers (refer to Appendix 1, Thomas Jefferson University & Health for more details on their Secrets Day initiative). Their Secrets Day campaign was successful because the campaign acknowledged that everyone is struggling and resources are available to support healthcare workers.
- Hackensack Meridian Health addressed accessing mental health services stigma through storytelling campaigns. The health system gathered and displayed testimonials from their healthcare workers that have accessed mental health services and highlighted their experiences. The testimonials were well-received and were powerful because they displayed healthcare workers like surgeons seeking services and having positive outcomes, hence, breaking the stigma of accessing mental health care. They also conducted a video campaign called “Unmasked” to address the mental health struggles healthcare workers faced during the COVID pandemic, collecting about twenty interviews, the health system was able to break the stigma of healthcare workers needing additional support during such a traumatic time (refer to Appendix 1, Hackensack Meridian Health Quotes for more details on their storytelling campaigns).

3. Working upstream to address mental health issues and social determinants of health in healthcare workers increases access to additional services

Present Challenges

In working with diverse populations of patients, interviewing hospitals and systems note that patients receive many benefits from their hospitals, systems, and their communities that address social determinants of health like housing, food, and safety, however, there is a stigma associated with healthcare workers needing the same services.

Solutions

- MetroHealth Medical Center combats the stigma of healthcare workers needing access to mental health services and addressing social determinants of health by creating a culture that treats the healthcare worker like a patient; healthcare workers are like an underrepresented group. Implementation of extensive and layered services such as supplying affordable housing and continued education programs; not laying off any workers and issuing raises during the COVID pandemic; and providing access to healthcare for their hospital staff to address the direct needs of the healthcare workers. Refer to Appendix 1, MetroHealth Medical Center Quotes for more details on how they establish a destigmatized culture of addressing social determinants of health in the healthcare workforce.
- Boston Medical Center created an organizational culture that understands the toll of trauma affecting the work of healthcare workers and worked towards fostering a supportive work environment. Their medical center’s social worker supplies meals and beverages on the job to connect with the healthcare workers and advertises the mental health services available. Their strategy is meeting the immediate needs of the healthcare worker to understand their other needs such as mental health support or basic needs. Refer to Appendix 1, Boston Medical Center Quotes for more details on how their social worker address the stigma of accessing mental health support and additional services.

C. Supporting Healthcare Workers on the Job

1. Focusing on healthcare workers' physical and mental health immediate needs while on the job promotes and increases wellbeing

Present Challenges

One interviewed hospital noted that healthcare workers are not “fooled” with pizza and prizes, but need tangible help with the physical and mental load that comes with being a healthcare worker. The immediate needs of healthcare workers go beyond providing occasional treats and parties. The interviewed hospitals and systems focused on supplying immediate relief to physical and mental/emotional needs in a way that best suited their healthcare workers.

Solutions

- Multiple interviewed hospitals and systems gleaned feedback from employee satisfaction surveys and the surveys revealed that healthcare workers wanted simple improvements like private bathrooms instead of using the same bathrooms as patients. Hospitals and systems that implemented these changes noted that these quick improvements provided respite for healthcare workers and improve healthcare workers' wellbeing.
 - Other improvements hospitals and systems made was having a comfortable place for healthcare workers to get sleep (if necessary) and supplying continuous snacks and beverages on the job.
 - For managing the daily stressors, multiple interviewed hospitals and systems implemented simple mental health techniques that healthcare workers can utilize while on the job. Six of the interviewed hospitals and systems employed mental health service providers like social workers, therapists, and resilience coordinators who remain on the floor with the healthcare workers to assist with simple breathing exercises, de-escalation techniques, and rapid responses to mental health crises. Having dedicated staff present to addressing mental health issues immediately supports healthcare workers while also providing tools and resources that healthcare workers can access at any time.
- ## 2. Conducting employee surveys to assess the actual needs of healthcare workers & continuously examining the appropriateness of existing programming forms effective and targeted programs

Present Challenges

In the final survey, an observable barrier was hospitals and systems creating programs tailored to their healthcare workforce, programs were more generalizable. Many hospitals and systems in the final survey noted underutilized existing programs, even if there were many options available. Multiple interviewed hospitals and systems conducted employee surveys to assess the needs to their healthcare workers and continuously examined the appropriateness of their existing programs to shift priorities if necessary.

Solutions

- Employee engagement and culture of safety surveys conducted by councils dedicated to healthcare worker support to assess the emotional wellbeing of staff and their attitudes hospital and system's culture and programs. The surveys' results drove the creation of strategic initiatives to address the issues employees are facing.
- Selected survey topics like loneliness and burnout conducted by multiple hospitals assessed COVID job stressors and examined how their hospitals and systems can inform access to relevant programs and services.
- Some hospitals and systems continuously collected de-identified data on the utilization of existing services like their EAPs and other programs within the organization. The data collection of these programs are what empower hospitals and systems to expand impactful services and retire programs that no longer service their workforces.

- Interviewed hospitals and systems went beyond counting how many staff utilize their resources, but then followed up with surveys on the usefulness of the service to ensure the appropriateness of the services and resources. This layered approach to surveying and data collection enable the interviewed hospitals and systems to create tailored data-driven programming for their healthcare workforce.

3. Implementing critical incident stress debriefing, peer-to-peer support groups, and response teams ensures psychological safety increases psychological safety among healthcare workers

Present Challenges

The final survey revealed that 75% of responding hospitals and systems utilized critical incident stress debriefing to increase feelings of psychological safety and about 45% of the responding hospitals and systems used peer-to-peer support groups to prevent suicides in the workforce. The challenges of implementing both critical incident stress debriefing and peer-to-peer support groups is about getting healthcare workers to engage in a meaningful manner and finding the appropriate setting to conduct both.

Solutions

- A couple of the interviewees interwove the critical incident stress debrief into the peer-to-peer support groups to provide a framework for how to talk through traumatic events while leveraging the intimacy of the peer-to-peer support structure. The hospitals and systems train peer support leaders and response teams with training in critical incident stress debriefing, dialectical behavior therapy (DBT) techniques, and other mental health first aid trainings to assist in the critical incident stress debrief and address traumatic events. Refer to Appendix 1, Thomas Jefferson University & Jefferson Health and Hackensack Meridian Health Quotes to see how these hospitals and systems used response teams to address traumatic events.
- While other hospitals brought in skilled personnel to facilitate the critical incidence stress debriefing. The skilled personnel is usually out-based and skilled in critical incident stress debriefing, and provided one-on-one sessions, which ensured the psychological safety of the healthcare worker.

Focus Group Key Findings

A. Peer-to-Peer Support Focus Groups

1. Engaging stakeholders that peer groups bring value and conducting survey staff to understand peer group needs

Present challenges

Generating buy-in from hospital leadership and fellow healthcare workers is challenging when starting peer support groups. Focus group hospitals and systems engaged key stakeholders to establish peer support groups by surveying staff to assess the need of healthcare workers. Once the key stakeholders saw the need for peer support groups, there was more incentive to initiate the start of peer support groups. Hospitals and systems created steering committees and councils to create impactful peer support programs.

Solutions

- JPS Health Network included the directors of chaplain services, EAP services, nursing, and behavioral health in the strategic planning/designing of peer support groups and supplemental programming. They also involved human resources and the risk management office to oversee organizational needs for peer support programming. Collectively, they were able to discuss best practices and lessons learned from previous initiatives and create a peer support program that worked well for the whole organization.

- Before implementing peer support groups, JPS Health Network conducted a pre-test survey to gather a baseline of the mental health and wellbeing of the peer support members.
- After enough time, the hospital leaders conducted a post-test to assess the impacts of the peer support groups.
- Now, there is a dedicated staff person that regularly assists and facilitates the peer support groups and formally assess the continued growth and support of their programs.
- St. Luke’s Hospital identified their peer group leaders with a sticker on their badge so that staff immediately know that the peer group leader was a safe person to talk with and had the proper training to deal with mental health issues.
- Lakeland Regional Health gave hospital leadership and managers talking points on empathy during difficult conversations while providing care and encouraged healthcare workers to talk to their peers about the various prompts together. This encourages peers to begin conversations; the prompts also create buy-in for leaders and their teams to continue talking through difficult conversations healthcare workers face every day and discuss coping mechanism.

2. Nominating team members to be leaders organically creates peer groups and weaving existing programs into peer support programming leverages resources already available

Present challenges

As mentioned in the individual hospital and systems interviews, creating peer support groups that meet the needs of healthcare workers remains a challenge. Focus group interviewees noted that the various mental health training not only increased awareness but also created mental health champions within their organizations. Once hospitals and systems establish their peer support groups, they bolster the peer support groups with existing programs.

Solutions

- A successful approach was to peer-nominate mental health champions and the nominees would attend training sessions to then use in peer-to-peer groups or other applicable settings if necessary (ex. de-escalating crises or behavioral health issues on the job). This strategy creates buy-in at the peer level and identifies staff that their peers already established positive relationships.
- When a peer was seen as a mental health champion, a culture that destigmatize care seeking behaviors and normalizes mental health issues emerges because they are a trusted person that understands the demands of healthcare work (refer to Appendix 1, JPS Health Network Quotes for details on mental health campaigns and peer nominated support leaders).
- Caring for the Caregiver program and Schwartz Rounds were listed tools and resources woven easily into their existing peer support programs.
 - Caring for the Caregiver supplied a framework of support geared specifically for healthcare workers. Refer to Appendix 2 for more details on Caring for the Caregiver program. Within the Caring for the Caregiver program, Schwartz Rounds (a technique to discuss acutely traumatic events in the hospital setting with whole teams and organizations), are utilized within peer support groups to recover after traumatic events. Refer to Appendix 1, SSM Health Quotes for more details on their usage of Caring for the Caregiver and Schwartz Rounds.

B. Employee Assistance Program (EAP) Focus Groups

1. Conducting mental health screenings like depression and substance abuse screenings offer opportunities for specialized care

Present challenges

An emergent topic of the final survey was monitoring healthcare workers for potential mental health issues. Conducting screenings for mental health issues such as depression and suicide allow hospitals and systems to prevent suicides in their workforce more effectively and create targeted programs based on the healthcare workers’ needs.

Solutions

- Henry Ford Health System’s EAP provides self-assessments and screenings for depression and suicide and supplies resources based on your assessment results. Bryan Health also provides online screenings for depression, but they also include screenings for alcohol, anxiety, and psychosis. The screenings inform the healthcare worker of their symptoms and supply resources and counseling.
- In addition to the screenings, Bryan Health implemented a mental health emergency room that is staffed with mental health nurses and social workers all day within their existing emergency department. Healthcare workers can also utilize the mental health emergency room if they are going through a mental health crisis (refer to Appendix 1, Bryan Health Quotes for more details on their mental health emergency room).

2. Utilizing technology like apps and portals for EAP services access and marketing EAPs strategically to raise awareness of available services

Present challenges

The final survey revealed that EAPs are the main strategy for implementing mental health services and suicide prevention within the hospital setting, but the remaining challenge is EAP underutilization. The focus group hospitals and systems stated the same challenges as well; the hospitals and systems collected data on EAP usage and reported underutilization of the EAP resources. The focus group hospitals and systems leverage apps, intranet portals, and campaigns to raise awareness of EAP services.

Solutions

- As stated in the individual hospital and system interviews, employee engagement surveys revealed the healthcare workers’ satisfaction and usage of EAP resources, offered feedback, and informed the expansion of services in the focus group hospitals and systems.
- Bryan Health uses an app that functions like an online chat that directs their hospital staff to the available resources. This strategy has increased the utilization of existing resources and programs.
- Henry Health System used a storytelling campaign to highlight stories of healthcare workers accessing EAP resources and the impacts the resources and services had on their mental wellbeing. The campaign raised awareness of the value in the various programs and empowered healthcare workers to utilize EAP services.

Hospitals and Systems Interview and Focus Group Quotes

The hospital and system quotes highlight their work in their own words. The summary and quotes provided fall into the preselected and emergent themes presented in the key findings section; the summary and quotes bolster the work that participants are doing around supporting wellbeing and preventing suicide in healthcare workers. For the resources listed in quotes, refer to Appendix 2. Quotes are edited for clarity or brevity, brackets ([]) indicate editing or abbreviating.

Interview Hospitals and Systems

Boston Medical Center, Boston, Mass.

A. Increasing Access to Mental Health Services

1. Implementing organization-level crisis intervention and bridging the gap for long-term counseling

"We do crisis intervention and then we do organizational level. [...] The individual piece, what we have noticed is many of our employees are getting lost in trying to navigate their way through the mental health care system. **What we've been, we've been kind of like a bridge to services.**"

"**We're actually laying the groundwork for good counseling.** So really symptom identification and symptom management and so being able to how do we manage the current symptoms that you're experiencing right now. And we do a lot of psychoeducation around understanding trauma, understanding how this is impacting you, normalizing our response."

2. Social workers are utilized and marketed like on EAP services for healthcare workers

"Social worker[s] being the actual benefit: This is where I think it was brilliant when Lisa hired me [social worker]. [Lisa's] a senior vice president of human resources. I live in the benefits department. I'm like a human benefit [...] **I'm a different version of an EAP, so to speak. And that's why we got like the employee resilience program. It's different than the EAP, but same concept that it's a benefit for employees.** So that's where I'm living right now. And I think that that has been huge."

B. Destigmatizing Mental Health Issues

1. Creating a culture that understands the toll of trauma

"Chronic trauma can impact the individual. So then how do you help manage that? Having that type of person in human resources makes a huge difference, because then they can kind of figure out what does the institution need. [...] right now I'm working really, really closely with our VP in Quality and safety. [...] **It's key because to be able to know the difference between somebody who has it's dealing with a depressive episode and who's somebody is responding to a really challenging event that's triggering something from their past, right and being.**"

C. Supporting Healthcare Workers on the Job

1. Promoting de-escalation techniques, like the pause method, while on the job in an easy way

“Throughout the workday, one of the other things is we have this pause tool that we have on our badge that we’ve been showing people this people have throughout the hospital. This is a way of deescalating a person who’s experiencing really big emotions at the moment. I’m sure you’ve seen it as the 54321. This works about 35 to 45 seconds. **Teaching people how to use their own body to regulate the nervous system. One of the big things we’ve been doing is resilience.**”

2. Providing food and other necessities for healthcare workers while on the job

“**One of the ways to advertise [mental health services] was food, right?** That’s the best way to get to people, to understand what we’re doing. During COVID actually we were able to use some of the COVID funds and I would push this cart around with tea and coffee and food to the inpatient floors. And they would be able to come. I would introduce myself and basically say, this is who I am [social worker for healthcare workers]. A lot of what I was doing was like, please know that you’re stressed, responses instinctual.”

3. Conducting frequent peer-to-peer support group meetings

“**Employee peer support groups are twice a month [with] trained facilitators. Open to anyone. Message this in the newsletter. Set time. Rooms are set. All they have to do is come.** Ground rules: whatever is said in this room, stays in this room. [Support groups have] died down a bit. But we still do it. There will be more pandemics and more crises. Want to be one step ahead.”

4. Piloting a stress continuum modeling tool (see Appendix 2, Figure 1) to have a shared language of healthcare worker mental health status

“**We’re doing a pilot. We’re going to try to use distress first aid model. My colleague and I created the training for the peer support training.** We just started the pilot in the ED (Emergency Department). We trained 6 employees to be peer supporters. All three of them were doctors. Two of them were nurses and one was a social worker. All we wanted it to be multidisciplinary. We have a couple of people who want to be trained for our next one that are.”

“**Once a month we meet for a designated time and we go over the stress continuum and then we basically say this is an opportunity for you to talk about any stress injuries you’ve experienced** over the past month and any communication issues, any difficult conversations, setting boundaries, having a difficult conversation [...]”

5. Addressing social determinants of health in their healthcare workforce

“**Another program in the Human Resources Department has been doing something called the Culture Code, which has been kind of incorporating some of some of this race and ethnicity, ethnic issues coming in.** We have another sometimes it feels like there’s too many tasks for us, but then there’s another task force working on that I absolutely love on. It’s called THRIVE. And they’re talking about the social determinants of health.”

1. Human Resources (HR) to support healthcare workers’ mental health issues

“Consulting and guiding the HR benefits and HR in how to navigate our supports for our employees and I think that’s the key. Whether you can afford a whole team or to build a whole program, but to have a behavioral health person who understands the intersection that’s going to be really important to understand the intersection between work and behavioral health services, right, and understands trauma and [the impact].”

D. Additional Information

1. Idea around sabbatical for frontline staff and the importance of trauma recovery

"I think it would be wonderful for the frontline staff, doctors and nurses who had to work during COVID **to be able to have a paid sabbatical where they get a trauma training care recovery period because they have gone through a war without ever expecting to have to go to war** without the resources to help take care of themselves through this war, and now they're being asked, OK, we're back to normal."

"You would have to take a sabbatical to find yourself and reassess your goals before you come back, right? **Some of the high tech companies know the importance of doing this type of thing, but we don't.**"

"[...] **frontline workers the importance of understanding trauma and understanding that recovery. You've gotta process and recover. Recognize how you're coping with it in the moment and then recognize how you're going to process this and how are you going to recover?** And so, we need to incorporate that in order to have strong employees [...]."

CHI Health, Omaha, Neb.

A. Increasing Access to Mental Health Services

1. Using simple mental health techniques to do while on the job

"Everything from just encouraging reminding and reinforcing simple things like deep breathing and taking time for yourself. **Whether it be posters on the bathroom wall, whether it be overhead announcements, whether it be emails that just kind of nudge people in that direction.** Elevate the visibility of the necessity of these things through having frontline workers participate in IRB research and then feeding back obviously those results so that we keep people educated on the on the value and the benefit of these practices."

2. Easy access to 24/7 EAP resource hotline for all employees

"**We also on our intranet we have a kind of stagnant and the top right corner. It just sits there. It's a bright green rectangle that says EAP and anybody can click on it,** and it pulls up that phone number and to call right away and make an appointment. It's readily available for employees and for managers."

"**We have an information referral hotline. We have a 24/7 crisis line that's open to any employees or anybody in the community at 717HOPE, very easy to remember. It's been in place for the last 14 years.** [...] if you're in crisis and you need to talk to someone now, whether you are suicidal or whether you just need to have someone to listen to, whatever that might be, that's available as well staffed by our therapist and the nurses as well."

3. Providing immediate mental health services onsite

“We’re integrated into 13 of our primary care clinics or our family health clinics, family health centers. It’s not a co-located, like you know, behavioral specialists or therapists, they are actually integrated into the team. So as a primary care physician or whomever has an individual that’s struggling with whatever anxiety, depression, whatever it might be, **they transfer them immediately down the hall to this behavioral specialist, which then they’re working top of scope with that individual.**”

“Even in the primary care setting or the outpatient setting, they’ve got immediate access to behavioral health therapist. We have two immediate care, psychiatric immediate care clinics. [...] **They really don’t think they can wait six weeks, 8 weeks, 12 weeks to get into, see a therapist or a Med provider. We usually can get them in within 48-72 hours.**”

4. Dedicated mental health staff for mental health resources and service implementation

“We’re really blessed to have him [Eric] and his role as Resilience Coordinator, but I’m not sure we called out one of the new programs we just started. And Eric is actually the lead of that right now and that’s called stress first aid. It’s peer-to-peer support.”

B. Destigmatizing Mental Health Issues

1. Utilizes the American Hospital Association’s (AHA) People Matter, Words Matter campaign posters within their hospital to start the conversation around destigmatizing mental health wellness

“[...] permissions of using the campaign, if you will and getting credit to AHA on the, on the posters and so on and so forth and so. What really sparked my interest in in some of the dialogue I had with the PR team and marketing team was. **They’re simple steps to make a big impact that while the focus is really around suicide reduction or health care worker knowledge related to suicide reduction or tendencies and knowledge, we’re such a big organization here in the Midwest that it’s not just patient focus, but if we can focus it on our healthcare workers within our organization, who then can take it to their family members or their children that they might be struggling with or their friends or out in the community.** That message, if you will, really has so many.”

“And this these tools were again just simple, you know shifts in just choosing your words of how you might approach somebody. So that’s kind of more the community as far as embracing our healthcare workers and their families, so on and so forth. But I also think the other piece of that is. **Oftentimes we find in our medical from our medical colleagues and I’ll just say nurses in particular, the fear of asking the wrong questions, saying the wrong thing. Is it OK to ask someone if their suicidal on an orthopedic unit or a women’s unit or oncology floor? Oh my gosh, what do I do if they say yes or how do I choose the words that I choose to ask a question could open them up or it could really shut them down.**”

C. Supporting Healthcare Workers on the Job

1. Healthcare workers are trained in Dialectical behavior therapy (DBT) to support other healthcare workers

“Started a training called DBT, [...] and part of DBT is to support one another. As we’re doing, you know, it’s almost like a mandatory part of DBT is to have support and we have like, a template. We go through [like] DBT therapist. What is it that I need to support myself so that I can provide that care?”

2. Conduct surveys to make programs tailored to healthcare workers' needs

"We have our employee engagement surveys that really and the culture of safety surveys that we look at and there's times where you know we can really see departments that are really. Not just from behavioral health, but system wide.

"I think it is really important that we continue, in the Resiliency Council would also be able, to identify even more broadly that there's a need for that as we kind of look at our employee engagement scores and cultural safety score. I think part of it as well is to move beyond just programmatic and various initiatives. But **to actually see resilience and wellbeing as a strategic initiative that informs and influences other aspects of the organization.**"

Hackensack Meridian Health; Hackensack University Medical Center, Hackensack, N.J.

A. Increasing Access to Mental Health Services

1. One phone number and virtual platform for 24/7 access to overall and mental health services

"We now have one phone number, just one phone number that anybody who needs help. They're struggling. They need assistance. They have a child at home with anxiety. They had a bad day at work. Whatever it might be. The line serves two purposes. It's 24/7. It's manned by behavioral health licensed and it's our own team members, so psychologists, social workers, and licensed counselors."

"We have had virtual, integrative health and medicine visits during the entire pandemic. So you can schedule it and that included a health psychologist to help you with, you know managing getting and keeping yourself in shape when everything else around you is falling apart, how do you how do you create a core for that caring for self-series which was every day seven days a week, five days, 5 sessions and a mindful meditation available to you on our intranet and our systems tablet and from we had a self-care series five days a week, three sessions a day, again taped and out to all of our staff. And then we had specialized, integrative nutrition sessions. **Seven days virtually by appointment. Everything that we do 24 hours, seven days a week"**

2. Providing a bridge to long-term counseling solutions

"We're really trying to make that warm hand off that direct connection to those longer-term resources, whatever the most appropriate resource might be. And that's the beauty of having a [...] professional person on the other end of the line to be able to say this is what I think you most need. [...] we had team members expressing suicidal ideations and we were able to involve crisis and get them admitted and [...], thankfully both did well. But I mean I think that that is an example of the way that line really works."

B. Destigmatizing Mental Health Issues

1. Hospital staff to engage in Psychological First Aid training

"We realized [peer-to-peer support group] was [...] created as a second victim program for our clinical teams which was incredibly important. But as COVID came around, [...], it wasn't necessarily an event, right. We expanded it to include our non-clinical team members because. It had always been, as I said, a second victim, clinical type of a program. We expanded it; **we made it much more about emotional support. It's a psychological first aid program and we trained many more people. We tried to make the program more recognizable.**"

2. Hospital management team trained in recognizing behavioral health issues and utilizing tele-therapy

“We trained our management team again how to recognize behavioral health issues, how to not react to him as performance issues and to engage those individuals and care in a non-authoritative fashion. So, making sure that everybody in the organization had the right attitude about what was going on with our staff and got ahead of it [...]”

“We did start during right before the pandemic of behavioral health, urgent care center, so that our staff and our patients had access for seven days a week, 12 hours a day stop in psychiatrist on demand. **We created the tele-psychiatry hub with over 2000 visits a week for our patient base and our staff.** So, our staff can access psychiatry quickly if it’s a medication issue, they could go in person to the urgent care center or they can use our tele-psychiatry. Yep, we’re doing between 500 and 1000 visits at the peak 2000 visits a week.”

3. Addressing mental health stigma with storytelling

“And the way that we’re doing that is through storytelling. And I think it’s very powerful that way. So, I’ll give you an example. **In the emergency department physician working in, in our biggest. And so, we were able to interview her and get her out there. And I think doing that, those kinds of testimonials are so critically important because it shows you that she didn’t lose her license. She didn’t use her loser hospital credentialing. She didn’t. People didn’t ostracize her. She got better.** And I think, you know, those are the kind of stories that we’re looking at that we have been sharing and that will continue to do and. And, you know, you asked what’s transferable to a hospital that may not have the same kind of resources? I think that’s something that is absolutely transferable as let’s talk to people who are experiencing this If you can find people you know, it’s not easy to get people to raise their hand. But when you do, I think it’s powerful.”

“We just launched a project called Unmasked and it is we have a videographer who’s going around the organization and then doing 5-minute interviews with our staff about their experiences during COVID. I think we have about 20 of those interviews now that are available. We just did a half a day at the carrier clinic where I spend most of my time talking to our staff about. So, what is what is it like during COVID dealing with patients who are coming to you because they’re fearful of COVID or it’s gotten to the excess, would you, how did that impact you and how did all the restrictions of COVID impact the delivery of behavioral health services? So, we’re capturing all that.”

C. Supporting Healthcare Workers on the Job

1. Conducting Critical Incident Stress Debriefing

“I think the critical incident stress debriefing is a really important point and it’s you know it’s another reason that having one number is extremely helpful because the person on the other end of the line know is OK, this is not something for peer support. This is something this is an event that requires somebody with a higher level of skill and training and were able to deploy those critical incident, stress debriefing and we’ve done a lot of them.”

2. Using harps to create a pleasant work environment

"This has been a fun project and that is helping our staff sleep well and our patients to sleep well. So, we have a project called Bedside Heart and we have harpists, **I have six harpists they come into the hospital. And then we do an hour-long harp session in every unit, and we have that. We have had meteoric increases in our sleep scores as a result of this in not only our patients but our staff.** And so, the staff that work better we try to make sure they're not falling asleep on the job so but while they're there but better quality of sleep because they're not walking out the door at the end of their shift. It's a just a web and you can see it's a pretty gigantic web of services that are available to all of them at all time in any kind of situation."

3. Piloting a tiered nursing response team

"We're just about to start a pilot at one of our sites and I believe my hope is that it's so successful. Then I'm going to be able to expand it across the board, but it's a holistic nurse response team."

"[...] we put 125 nurses through something called the Birch Tree Center for Health Care Transformation. So, they got a holistic nursing certification. And what we're doing is **turning those nurses into a team that look after round on their own team members. Right. So, we're going to pilot it at one of our hospitals and sort of see. But they do things like hand massage, healing touch, therapeutic communication. They're trained in psychological first aid and they take shifts wherein they go into the hospital and just focus on taking care of their colleagues.** So, I'm really excited about that. fingers crossed that that our outcomes are as good as, as I hope they will be. And that will be able to really take it across the network."

Hartford HealthCare, Hartford, Conn.

A. Increasing Access to Mental Health Services

1. Collecting data on EAP services utilization

"We collect proxy measures including utilization of EAP and peer support, number of times outreach is sought for a colleague in crisis, number of times QPR is delivered (plus pre and post survey data); we have done qualitative workforce surveys as well (assessment of confidence/competence in BHN, primary and specialty care)"

B. Destigmatizing Mental Health Issues

1. Participating in the Zero Suicide Program and Question, Persuade, Refer (QPR) Training

"Zero Suicide Program-It's just the right thing to do. Really worked hard to imbue the 7 core tenants in the culture. The BH (Behavioral Health) workforce was being treated like they were supposed to take care of patients and the workforce. [...] Zero Suicide has sustained over the years with at least 50 dedicated volunteers."

"Zero Suicide leadership, including BHN leaders, Quality and Safety leaders and staff (approx. 50 volunteers from our Behavioral Health Network, primarily clinicians), Well-Being Department leadership, and many local partners/stakeholders (clinicians/SMEs, HR, Experience/Engagement, IT (Information Technologies) and Clinical Informatics)"

“We have been doing QPR for a long time. We’re very good at teaching suicide prevention to clinicians. We needed a way to teach lay people/non-behavioral health people about suicide prevention. We have been doing it for a long time. Hospitalists wanted us to talk – we did QPR – and we talked about what if a colleague is suicidal – response “not my job” they could lose their license. They would hate me. I think we have made progress. There is a difference now. “Suicide is everyone’s responsibility. We have to take care of each other.” ”

C. Additional Information

1. 1. Suicide prevention program elements and advice for how to start a suicide prevention program

“A broader part of our mission is to stratify our efforts to meet the specific needs of different disciplines, address cultural and gender differences, and include individuals with lived experience. These are long-term goals. **Our vision for an ideal healthcare worker suicide prevention program includes 4 elements:**

- i. Education/Training
- ii. Support Resources
- iii. Creating a Culture of Well-Being
- iv. Policies/Procedures”

“Start with a charter that includes clearly stated goals, objectives and scope. Obtain executive sponsorship and collaborate with relevant stakeholders internally and externally. [...] reap later benefits including fewer suicide deaths and attempts. Benefits also include a workforce that cares for themselves and others and is confident/competent to ask about suicide risk and respond to those in crisis.”

MetroHealth Medical Center, Cleveland

A. Destigmatizing Mental Health Issues

1. Understanding healthcare workers need mental health resources just as much as community members do

“Our employees are our patients as well. And when we start thinking about underrepresented groups,” *(see supplemental video on MetroHealth culture in Appendix 2)*

B. Supporting Healthcare Workers on the Job

1. Recognition and awards structure for healthcare workers

“It’s really around a campaign that started out as merely a reward and recognition. It’s called “All In”, **We got feedback on one of our employee engagement surveys, we don’t reward or recognize.** We went ahead and got a platform where I could say, “hey, you know, Rebecca did a great job”. I’m gonna give her five points and you get a certain number of points, and you can get fabulous prizes. **So simple rewards and recognition program and I could send you a little E cards say hey, thanks, I appreciate what you did, and I could send it out where it went to you, your supervisor or I could post it in general, where everybody across the system could see it.”**

“One of the things we learned was sometimes just saying thank you. In the middle of COVID, we gave everybody a raise. We didn’t furlough anybody. Rather than lay them off and we gave him a raise because how dare we not do that? How can we redeploy those resources? Because we realize so. Going back to those social determinants of health.”

A. Increasing Access to Mental Health Services

1. Offering comprehensive, anonymous, and offsite mental health services

“You need to offer offsite. Stigma. Known barriers – we systematically designed a program to reduce known barriers. Have to provide accessible services by those with credibility that are not involved in the evaluation of residents. [We] made sure treatment record was outside of hospital EHR. Cost is another barrier. Residents are in dept. High co-pays are a barrier. Time is also a barrier in terms of schedule. Fully funded by health system. It’s free. They don’t bill insurance. No paper trail. Unlimited care. Major depressive episodes require many “doses” of treatment. Currently [there are] 3,000-4,000 physicians who can access this program. Highest rates of utilization. [We] see 1/3 of all residents. 12% of all faculty.”

2. Increasing visibility and credibility with available programs

“Be visible. Go to all orientations. Workshops where we do to residency programs. Grand rounds. Walk around on campus. Lead support groups. Attending [physicians] refer each other, they will say “hey I sought help through the wellness center. {We} created a culture to step away for an hour to get some help. Share stories. Need care that is tailored to their needs, tailored around residents working 80 hours / week. They can access care in the community”

B. Additional Information

1. An ideal program requires a layered approach

“Very influenced with the JED model and the American Suicide foundation checklist. In terms of us, culture change, stories we tell, messaging, caring for each other, peer support. [...] Courses on coping skills. We need an environment where folks feel respected. We could offer more expertly run train the trainer on how to teach coping and resilience, WHO (World Health Organization) has invested groups in lay people in developing countries. [...] Another area in post-vention is prevention. Every institution should have a crisis response.”

Thomas Jefferson University & Jefferson Health, Philadelphia

A. Increasing Access to Mental Health Services

1. Ensuring anonymous and private care

“People can access privately without going through the EAP without going through a department in the system. And we think especially for the doctors and nurses who are the last ones to seek help that this is an important intervention that has been expanded now.

“[...] HR support so that you can actually go in privately and get connected with a therapist. And these are trained, mostly psychologists and other experienced therapists who work with healthcare professionals. ”

“Marvin, as another resource, we did that in December and within the first month, **75 people were placed with therapists.** [...]we would never be able to just do that in the traditional clinical model of a behavioral health department within a hospital system, So I can go private pay and there’s people over or even over an integrated medicine who do some, you know, counseling and so forth. We had the Department of Psychiatry, we had the EAP and then we have all the sort of peer to peer or programs that we have as well. So I think having that menu of services is really been helpful for us. ”

2. Compiling information for self-help

“How to take this Wellness model and apply it to the physician work environment? All of these entities are out there now, carrying the flag, and they have these resources in hand, so they’re different ways to get to this, but it all starts with tier one of this pyramid which is self-education. Go in there and all come with the blessing that people like Matt and Dina and others have looked at these materials. They’ve created some of them.

“How to take this Wellness model and apply it to the physician work environment? All of these, all of these entities are out there now, carrying the flag, and they have these resources in hand, so they’re different ways to get to this, but it all starts with tier one of this pyramid which is self-education. Go in there and all come with the blessing that people like Matt and Dina and others have looked at these materials. They’ve created some of them. **Some of them are borrowed out of literature and stuff. They’ve all been vetted and it’s a trusted website to go to. It’s kind of like our Web MD sort of thing in house for mental health.”**

B. Destigmatizing Mental Health Issues

1. Equipping young healthcare workers with mental health knowledge

“Was that this was a highly stigmatized issue within this population of individuals like, you know, they weren’t coming forward and saying I’m depressed because the fear is if I say that, then my, you know, attendings or residents that I’m rotating with will basically say, you know, we don’t want you on this.

It needs assessment that we conducted to best understand what the needs were on our campus. That also gave us enough information to say we really could bring on more staff and open the certainly all of that. We had six different colleges within the university and all six colleges reported on this. We’ve got a great response rate from students and what we found from that survey was there was in fact the need for behavioral health services across all of them.

You know, we certainly know in medicine it’s a hierarchical structure. You can’t simply teach the students a bunch of stuff and expect that everybody above them is gonna just fall in line. You have to kind of teach it at all levels. Otherwise what happens is the students are learning some great stuff. They go and report back on a case to a resident, and they say, why did you ask that? And they never asked the question again. And we did it through a parallel process because we knew if we could teach him how to, like, examine their patients in more effective ways and assess them in more effective ways and look for warning signs in their patients. We also are teaching me how to pay attention to these things within themselves within their peers within, you know, their supervisors sometimes too. And so it was a that was really the way that the program started and evolved, and it really. I think it was before COVID started that this was expanding beyond, you know, just the students we were getting into the House staff before that.”

2. Creating a “Secrets Day” to show that everyone struggles

“The idea was that we’re gonna have a Secrets Day. And there were some, you know, free lunch on the Plaza and all this kind of stuff. But the students were going to write down their secrets, deposit them. And then they be examined and there be conversation about this. **But the end result was there were an overwhelming number of secrets. I couldn’t believe that things that were disclosed that created a video that they put together that video got promoted and it would find its way back into the various clinical departments and rotations and parts of the university.** And it told us that these things are on that tips of their tongues and if they could find a safe way to bring this forward, it would work.

Fast forward to what **we’ve been trying to do as we get into this more recent phase of the pandemic is to hold on to these issues and those techniques and bring information out. And so finding private channels for people to go assess their symptoms, to find resources without going into our website** for them is what we’re using a company called Neural Flow.”

3. Using Marvin tele-therapies and the SAMSHA model to reduce the stigma of care-seeking behaviors

“And we also have another company that we’re partnering with called Marvin. It is providing the therapy there. He is asked myself and a colleague to take what we’ve been doing and move it into what we call a holistic health model. So **we’ve been building that off of the SAMSHA model for holistic health and Wellness. It is trying to teach us as clinicians how to better take care of our patients. What if we taught ourselves to take care of ourselves the way we’re promoting taking care of patients?** And so we’re we just presented to the 300 top executives for our enterprise on this issue and how it relates to physical health.”

C. Supporting Healthcare Workers on the Job

1. Creating a culture that specifically meets healthcare workers’ needs

“Somebody actually complained, they said. You can’t fool us with pizza. **Wellness needs to pervade the entire organization. So we we’ve got a dialogue going with our employees about this at different levels.**

They put together a rapid response team that I’m part of, that we’re going to be looking at. **How do we develop a better culture about meetings? When are they important? How long should they be, how many bio breaks should you have? Should there be reflective time?”**

2. Training staff in Dialectical Behavioral Training (DBT)

“**Started a training called DBT. I’m sure you’re familiar with DBT, OK, and part of DBT is to support one another. As we’re doing, you know, it’s almost like a mandatory part of DBT is to have support and we have like, a a template. We go through about as a DBT therapist.** What is it that I need to support myself so that I can provide that care? And so I think that there’s little pockets of that.

As well, I know the DBT therapist and outpatient meet together the PRTF which is our residential treatment facility. The therapist and group works together so you know we have these little pockets of of kind of you know support that that happened as just part of how we do our day-to-day operations. So hopefully you know.”

3. Conducting employee surveys to understand and support relevant needs

“**But you know we have our employee engagement surveys that really and the culture of safety surveys that we look at and there’s times where you know we can really see departments that are really. Not just from behavioral health, but system wide.** And so for example, you know, meeting with the palliative care group that really struggle with end of life work, especially during COVID and a death and on maternity ward and you know a really a child that came in to the ED that had died and just, you know, when you think about all of those kind of stressors that happen when we in healthcare experience.

I think it’s **really important that we continue that in the Resiliency Council would also be able to identify even more broadly that there’s a need for that as we kind of look at our employee engagement scores and cultural safety score. I think part of it as well is to move beyond just programmatics and various initiatives.** But to actually see resilience and well being as a strategic initiative that informs and influences other aspects of the organizational.”

D. Additional Information

1. Advice on how to make successful programs for healthcare workers

“The implementation can be extremely robust and you know a sense of pride and a sense of energy all around that you’ve got to be able to have something that has teeth into it that can sustain because as quickly as the energy can flow around implementing it, there’s other priorities that kind of come into and it ends up getting sometimes lower and lower and lower on the priority list that before you know it, you know, years gone by and whatever happened to that program that we were so focused on.

Also saying that financial component of that when you know supporting positions like this that you know you have a laser like focus on someone that owns it that can lead it, that can facilitate it. But there’s also got to be that when budget cuts come or when we’ve got to pull back on things we’re notorious for pulling back on programs or pulling back on educational opportunities because that’s the easiest. I’ll pull back on or, you know, we’re stopping stimulating. We stopped spinning staff to this 4-hour training because it’s nice to have, not man. You know, those sorts of things. So I think there’s got to be a consistency that it has to. Eric explained much larger implications to the overall organization and the enhancement of its resiliency as running water throughout the organization versus just kind of waves kind of ebbing and flowing as they come. And we’re trying to.

[...] a simple response would be to not treat this like a social program for the benefit of the employees but treat it like a strategic initiative that drives the economic engine of the organization. And so, really focus on the return on investment and make that clear to leaders. So that there is an economic incentive to ensure that it’s resource properly, that it is staffed appropriately and not treated like a training and development initiative.”

Trinity Health, Minot, N.D.

A. Increasing Access to Mental Health Services

1. Conducting early interventions for mental health issues

“This is our newest project. We do have a LCSW who sets aside 1 hour/day if anyone needs attention or needs an appointment. Collaborative team to make sure things are monitored. Hospital did purchase an Orexo program. Computer system – like an AV therapy for depression. One for addiction. Hospital is given a log-in, and individuals create accounts and you can pick what you need. If you are having marital issues, for example, you are put in touch with a counselor. Kind of like a video game. Critical incidence stress management, compassion fatigue training. The biggest part is identifying issues early. We have done some education with department leaders, so they know there is support. If someone isn’t acting like themselves, you need to ask them. You can say “what is going on? You don’t seem like yourself.” **Key is identifying there could be an issue. We need to be present for our staff, and put ourselves out there.”**

2. Ensuring private access to mental health care

“If we know someone is coming in, we try not to let one another to see each other. We are constantly reminding people that things that are said and heard and kept private. Staff are very good that if we have an employee that seeks assistance, or ends on addiction or acute unit, we make sure that they will be cared for, not judged, and information will not be shared. Concern about losing a license or if it gets on my record, could be terminated. Most health care boards I’ve worked with, would rather staff seek help before someone gets hurt.”

3. Providing mental health resources for all hospital staff

“Anyone that walks in the door can seek help. Volunteers. Dietary. Everyone has been effected. We think we could have prevented undue stress if we had this before the pandemic. This is why this isn’t going away. Primary value is we are preventing staff from leaving. [...] we have staff that thought they were going to leave, but have decided to stay when they find out how to cope. Wonderful domino effect. No negatives to it. If the cost overall of a master’s social worker and it prevents with losing 1 nurse you have paid for that advocate for that year. [...] In our outpatient clinics, we stratify based on services. Many of our staff utilize outpatient services.”

B. Supporting Healthcare Workers on the Job

1. Having a social worker on staff dedicated to healthcare workers’ support and mental wellbeing

“Masters level social worker that came to us – she, CNO, and I formulated a plan to best utilize her specialty and her interests. **She had been a crisis counselor before, and wanted to expand upon her skills. Many staff did not feel comfortable going to peer support groups. Wanted to reach individuals directly. She works M-F and does rounds throughout the hospital and touches base with the staff. Initially, she got her name out there. If someone was struggling, she would sit down and talk (not therapy) but could ID need for crisis intervention and could escalate if needed. She also reaches out family members, if needed. She develops a plan.** This position isn’t a money maker position, but it’s so important to let staff know they are there. She make sure she was present to see if anyone was struggling. Normalize this for them so they know they weren’t alone, and there were others that were struggling.”

“Can this be translated to other hospitals. Job description is very self-explanatory. Could be used in any system or clinic. Just need a trained person. Doesn’t need to be a master’s social worked. Would need crisis intervention training and many bachelor programs cover this. Even a nurse with a BH background could do it.

Advice to other hospitals creating the position Worked with CNO directly our senior leadership is very accessible. However, we are a small system. Need someone with the passion to keep it moving forward. Full time position that is not billable. Financial piece to this. But the positivity to have someone to talk to, you have less people taking off for mental health days, leaving the field, etc. Lots of ROI here.

Biggest challenge is space. Where to find a place for her to go to. She is housed in a separate place at the hospital, but she’s seldom in her office. Another concern: who takes care of the person who takes care of everyone else. Her burn out. A concern long-term to make sure she’s OK. If she burns out, we will give here vacation time.”

Peer-to-Peer Support Focus Group Hospitals and Systems

Atrium Health Cabarrus, Concord, N.C.

1. Conducting different types of peer groups and tracking the effectiveness of the peer groups

“But we have about 40 plus peer support peer supporters that span all different types of professional levels, physicians, nurses, AP, some child life specialist, this kind of thing. So the work but like I tell people the need for this existed well before the pandemic and certainly when we are just reading about this in the history book, there is still going to be a need for.”

“The more in depth meeting one on one we require a follow up with that where you’re hey, do you mind if I touch base with you next week? Those all along we’ve had a tracking tool just for tracking metrics. Like what level of a provider or you use provider loosely in the term of nurse, physician, whatever level and just a brief information about the encounter if you provided any resources, what was it due to a patient death COVID workplace violence again just for tracking metrics. Our leadership said we need to be tracking that tier one because that’s 60 to 80% of the encounters that you have. And so I had a meeting with Sue and asked her does anybody have tracking metrics for the tier one? And she says not to my knowledge. So we developed 1A quickie who what, when, where, how and it’s linked to red.”

2. Conducting QPR Training and suicide prevention

“The QPR training is part of their peer support training. I’ve just I just recently took that at a meeting a couple of months ago and I know here at it waited for School of Medicine. We offer it to all our students.”

“At Atrium in our behavioral health setting, we trained everyone in QPR and it was interesting because like I said, I’m a therapist and there are a lot of therapists who work there. And so you say, hey, we’re gonna do this QPR training and they’re like, OK well we’re therapist like we know this. And interestingly enough, I went to Graduate School so long ago that we didn’t really have classes about suicide prevention back then or anything. Looking out for each other kind of this peer to peer idea, you know and asking the questions and really being in tune when you see someone who’s upset. Our QPR training got a little bit more personalized, it was really cool. We had we had her meat initially with like some of our leaders as well as our physicians even and you know I think sometimes people think they’re above that kind of a training but it really can bring you back and go.”

3. Collecting data on the “second victim” phenomenon

“We’re talking about even our physicians and we actually use our survey tool for our pilot area was the second victim experience support tool. With that, it is three different components to that. The first one was you know have how you felt after being involved in like an adverse event. I felt sick. I wanted to quit. I was scared to do work. I became afraid to do high-risk procedures. And then the second two components is desired support and then organizational support but yeah, I hope and as a society we are moving in the right direction but I think with a lot of these.”

4. Kate Spade Suicide Prevention Resources

"I share with our peer support team. **Kate Spade has mental health resources and if you go to the Kate Spade website, you can download all kinds of stuff. And there's actually even I actually saved it. This was one of my I shared with our leaders.** There is an IT organization that has a peer support program and I'm like OK, first and again this is my ignorance. I don't understand why it needs peer support more than health care workers, but obviously there's a great need for that as well."

JPS Health Network, Fort Worth, Texas

1. Engaging stakeholders effectively

"Our leader of the chaplain services are director of our Employee Assistance Program and our Executive director of our nursing and behavioral Health. And so, between the four of us as well as HR as well as risk management and patient safety side of things came together, really trying to explain what the program was and what it would be doing for our organization.

Getting those stakeholders together and then what we did was think about which are the areas that may need this sooner rather than later. So, I'm not JPS Health just like one hospital, we have several clinics. And so, I'm housed in the main hospital.

We were just really looking at the inpatient side 1st and we're still kind of there right now, which are the areas that would be impacted. So, we identified Ed behavioral health, our intensive and progressive care units. And so that was going to be like phase one of that implementation process."

2. Training peer support leaders

"Peer support training for actually via zoom we sent out [..], he created a video that can be found on YouTube that gives kind of like the research behind peer support programs and the evidence related to that. And that was great because it cut down the training from potentially 6 hours to about four now. What we do is send kind of like a pre work. To our peer supporters and what they do then is watch that video kind of get that background and then when I get them for the training, we're really intensively practicing the skills processing, what they'll be doing, answering their questions and all of that and so.

About the program, **we currently have 46 peer supporters at JPS this Thursday I am bringing in 30 more and so we've been able to grow this you know because it's just myself.** And the other thing about this is I also trained eight other instructors who are leaders in my network so that's helped a lot kind of because once the pandemic hit, they all got very, very very busy. What I've been doing is myself and one of my other instructors will train together. So, this Thursday I'm training with one of our message nurses, who was an instructor. So, we have nine instructors total, myself included. **I'm looking to bring more because as we are thinking about how to grow the program, it's gonna be more difficult for me to always Co-instruct with someone. But I will obviously have to be there too."**

3. Nominating team members to becoming peer support leaders and supporting team leaders

“At least go through everybody’s first training, so we’re still again heavily in the implementation process and it hasn’t gone perfectly by any means. It’s really just about. Figuring out which units are ready and prepared for that, and to really just jump on that opportunity. We were able to work with actually our women’s services was one of our bigger trainings. **What we do is we have our team members nominate their peer supporters. So, this is a lot of heavy lifting on my part, but it’s worth it because that one-on-one interaction is actually really critical with them. We have the I go to huddle, I go to their department meetings and I share about the program.**

I have all of the team members on the units present I attend that they get to kind of know me face to face because it’s rare that we have that these days. And so, then I sent them like a link to nominate up to three of their peers to be to become peer supporters. Then I take those names that I’ve that have been nominated and I send it to their managers because first I need to figure out are they in good standing.

Luckily, we have not had that issue yet, but **I want to do that checking with their leaders to ensure that they are in good standing and actually are good candidates for the peer support program. Once that leader signs off that yes, it’s a go, I reach out to them personally and I say, hey, congratulations, you’ve been nominated by your peers to become a peer supporter. I give them information again about what the program is kind of what they’re duties and roles will be, which also they’re leaders know and are aware of that.**

And then I asked them, do you want to become a peer supporter? Is this a good time for you? Is it something that you wanna wait and hold off for a while? I want to give them the option of joining at the moment or even joining later or not joining at all. Once they give me the go ahead, then we try to get them into our scheduled peer support training.”

“Of course, **their leaders can attend and it’s great for the leaders to know what their team members are doing, but also for the leaders to support other leaders. So, one of the initiatives that I did last year with our Caring for the Caregiver team was leader enrichment groups because we were finding that leaders were feeling so extremely isolated while trying to care for their team members trying to navigate the pandemic, trying to figure out what to do with staffing all of these different challenges.**”

“And our team members had access to support, but our leaders were feeling more and more isolated because they really didn’t have too many people to talk to. So, within that leader in Enrichment Group really now I’m driving our peers of our leaders to also become peer supporters because they can support their colleagues as well as their team members. So that’s kind of where we’re at now. But we’ve been evolving the process as we go. I feel like we learn something new after each training.”

4. Assessing peer support group effectiveness

“We created a pretest for the training and a post test. So I do that as data collection, but also we have monthly peer support meetings because we don’t wanna leave those peer supporters isolated because now they’re carrying the thing they probably they took on this role and they were probably doing it before. But now that it it’s more formalized, it’s more at the forefront of their minds. So what I do is I meet with them once a month. I give them several options for which meetings they can attend because we have day shift and night shift and weekends.

My role is really to be able to support them and meet them wherever they are. So whatever hours they need, I’m gonna make it happen. And that’s my duty. And what I do is just hear from them how things are going. We’ve improved lots of processes from kind of those informal meetings, but we also have a formal evaluation tool that we give about six months after they’ve done the peer support training. And then we’ll do it again after a year just to get as much feedback as possible and as along with that evaluation.”

5. Establishing organic peer support groups through on-the-job conversations

"[...] Is to talk through because they all say the same thing. I don't think I really did much like. I don't think that was peer support. And then we started talking about, OK, what actually happened in those circumstances? And when they're describing it, I'm like, yeah, that was definitely peer support. And I just remind them that this comes so naturally to them. Again, these are the people that everyone on their units goes to to talk about whatever is happening personally and professionally that they think it's normal. And I'm like, I use myself as a therapist."

"Ongoing conversations with them to get to that point and I'm hoping maybe they even talk about it when I'm not around, maybe they feel safer just talking about it in their small groups. But even in our QPR training I share stories of like my cousin who went through suicidal ideation but like if I didn't share that, they're gonna think this is just a webinar. We're just gonna go through the skills like we have to get very real, very fast. And I think that level of comfort with the content and personalizing it goes a really, really long. With helping to destigmatize that's I think everybody had the same kind of or similar baseline of ohh wow, we're all really, really stressed out by this one thing. We had this shared experience that kind of allowed us to talk more about our shared experience of mental health."

6. Conducting QPR Training and suicide prevention

"I've been doing QPR training so I actually started this with our residency and fellowship programs, so all of our trainees at JPS, our QPR trained gatekeeper trained and once I launch the peer support program, that training was already long enough. It's still 4 hours and we're working on figuring out how to break that up. But in those monthly meetings that I talked about, we use some of that time for continual education. I've incorporated after you've been in the peer support program for a few months, our kind of settling into your role, we start doing some ongoing education and one of those is the one hour QPR training because this has come up with our peer supporters and those monthly meetings. **I'll talk about someone who was expressing vague suicidal ideation or very overt suicidal ideation. And so this has become an asset to add it onto the continuing education for our peer supporters."**

"A support across our network for suicide prevention and a part of that work will be through our peer supporters, but I just want to get more of that awareness out. **And so the other team member who's part of our Caring for the Caregiver team. And I wanted to build something off of that, but really have had challenges with that. I'll tell you one of our struggles has been our communications department with the use of the word suicide. And so it's hurting deeply in my soul that I have to find other ways to talk about this, even though the best thing to do is to just talk about it."**

7. Advice for how to start healthcare worker wellbeing programs

"You just have to hit the ground running and trust that you kind of know what you're doing. But I feel like there are so many similarities in our experiences of building these programs, but there's also those kind of individual network nuances. And so whatever those things are, you'll figure out over time you'll figure out what your best practices are over time. It does not happen the first time around.

Not one bit, but once you start, you'll get that momentum going. And I think just keeping in contact with the people who are stakeholders for this type of work who are really help you champion it is really, really important and having communication with them and just kind of being able to report out what's coming out of the peer support programs will help sustain it as well. "

1. Existing barrier: ensuring that peer support leadership have enough staff to be effective

“ I am the lone champion for peer support within our organization. Everybody loves the idea, but there are no resources as far as FTE in order to dedicate to this and the team that I would normally rely on as my super users and champions for programs like this, they’re already so burnt out there beyond crispy. So the concept of trying to enrich them, the people that would normally have even been on like my debrief teams.

They’re spent. They’re tapped out. I also have a team of therapists, right? We have a robe. I mean, **I have a really, really large psychiatry contingency if social workers therapists, that’s something I’m very lucky to have. I’ve relied on those people in the organization, has in general. But again, those people have been really pulled because of the behavioral health demand. So it’s this constant, like, you have this awesome plan. I’ve written this proposal multiple times and then it gets whittled away like you’re sharing. So one of the a couple of the things that we did. And again, I cut back to me in a year. And I’ll tell you if it’s best practice.”**

2. Granting peer support leaders direct access to EAP services

“The other thing that we happen to also roll out in January and New EAP contract and I’ve been really pleased with our new EAP provider. We have instead of us doing the additional training because again just the plates have been full. We have started to supplement the training with modules from our EAP and all of my peer supporters have a direct contact at the EAP if they need to get an individual in quickly.

Now it may be an email or you know they can always call the hotline, but that has been something that has just made people feel more connected. So they have, like, there’s a couple people on the team, including myself. If we were to have, like, a real serious suicidal type, you know, team member, which we have had, we have had that situation before, I typically will get a secure text at whatever hour, time or day. We sort of have a couple levels that that individual can kind of bump it up to. And generally speaking, that team support Chaplain has just been worth it.”

3. Using the University of Missouri Healthcare Framework for peer group implementation and studying peer support group outcomes

“As far as tracking of our metrics goes, again we use the University of Missouri Healthcare Framework where you have the three tiers of intervention and it sounds like most people are familiar with that, that program. And so we initially started like they and because most of you, the majority of your interventions are just like you mentioned Alice, you just go up and I call them drive by us. When I’m educating our peer supporters, these are your drive-bys at the nurses’ station.”

“Doing a peer support study to really look at the framework of this and what are the outcomes now. I’m using the PTSD for primary care scale and we’re using the mental health seeking behavior scale. So those are really our three key measures and we’ve done a lot of pre measure for both units that have peer support in place and units that are controlled that currently do not have it. We’ve done all that through an online very quick.”

“QR code can scan, so I have a good amount of baseline data and we are continuing to check that at one month, three month, six month, nine month and a year. And we’ll just track those over those various nursing units to see how is the anxiety, depression, PTSD and this mental health seeking behavior where it goes. So that’s kind of our story in a nutshell.”

4. Advice on establishing empathy culture and implementing impactful programs for healthcare workers

“But now what I find is that because we did that and we got into the habit of talking with it at that group and it was all kinds of things we would talk about journaling or we would talk about, **you know, how to deliver bad news with empathy. We would talk about being vulnerable. We would talk about current events like, you know, what various things like going on a media diet, like all the little things that you would want your peers to be out there talking about. We would give the managers talking points who aren’t normally comfortable talking them around mental health.**”

“**It’s gonna be messy and not perfect, and you’re never gonna have all the resources that you want**, but I think the call started out and I think, Lucy, it may have been you that shared that with that, if you’ve helped one person, it’s already been a success and that you’re going to, it’s going to take a couple failures. You’re going to have some people to sign up and don’t like it. You’re going to have some trainings and have no shows and all that, but you just have to start it. **And I think it’s one of those things that takes a long time to really make the kind of cultural shifts we’re talking about here. So just continuing to nurture the program, having the right people involved, that are really passionate.**”

SSM Health, St. Louis

1. Applying a tiered approach with the Caring for the Caregiver Program and Schwartz Rounds

“**I think we have 23 ministries or something like this that crossed four states and our Care for Caregiver program has been in varying stages of implementation and so some of our ministries have very robust programs.** So in our Southern Illinois Ministry is and our Oklahoma ministry is, but then others have not been able to make it a sustainable program. What we have just run into some ongoing barriers where the same we’ve had a tiered approach where we have a tier one training where everyone gets it’s very brief training. Tier 2, which is more extensive that used to be the four to six hour training, but that had become such a barrier that we’ve been trying to even streamline that. What we’re looking at right now as we roll our planning to roll this out across our system, across all the ministries and all 33,000 employees.”

“That what worries me a little bit is that that’s not enough time. **We had planned to bring people in to do the training at 90 minutes and then have that ongoing development to do that same ongoing support and development at the time.** The other thing that we’ve learned, we had the opportunity to work with the Harvard Lifespan Research Foundation. We were working with several of their psychiatrists and the one of their psychiatrist, Dr. Mike Navarez, he has been able to streamline all the different trainings that are out there, so that it really is able to get that four to six hour quality training in that shorter time period. **Leaders Support Ministry support through Schwartz Rounds and then actually that active kind of in an acute trauma event. The respond and recovery. So we’ve been doing some actually EMDR outreach and trying to do more of that trauma response.**”

2. Having physicians participate in QPR training and use a mental health continuum to help healthcare workers discuss mental health issues with shared language

“And for keeping in mind that physicians also need it because, like we did at QPR, we did an abbreviated version of it, but we had had a physician here locally that had death by suicide. And actually it was a horrible, tragic because he also took the life of his daughter, who has had special needs. **And so shortly thereafter, we did well, months after price, six months after we did it, the abbreviated QPR training, it just opened up the door for these conversations that don’t think otherwise would have happened. And so and since then, we’ve had multiple people, multiple physicians become certified in mental health first aid.**”

“So job stress being one of them, of course another big bucket. But work life balance and recognition. So ultimately try to help improve and wellbeing by focusing on those three areas with a lot more intention. **But during all of this we spent a lot of time talking about just the self-awareness piece and use the mental health continuum model adapted it a little bit so that it had some signs and symptoms that you could see if you were in the green or if you in the yellow or the orange red.**”

St. Luke’s Hospital, Kansas City, Mo.

1. Understanding the “second victim” phenomenon and conducting a hybrid peer support groups

“And then we kind of took that and then created a little hybrid program. At St Luke’s, we had a program called when caring Hearts. And it was kind of an introductory health stream program that people are employees could take on their own kind of gave them an idea of what resources were out there at their at their request, understanding the second victim phenomenon and how they can benefit from talking with other folks. And then we took that and we did a didactic training program that we pulled our education group. The behavioral group in and then our spiritual Wellness team, which is a big part of our wellbeing program at St Luke’s and we pulled together kind of a hybrid peer support training we took.”

2. Conducting Psychological First Aid training

“We took Psychological First Aid training. We took the first responder training and then we took the training from the University of Missouri as well and kind of combined it together into a four-hour didactic training program in and above the two-hour basic course of everybody took. We decided to pilot it at St Luke’s North. We had the motivated team member Stephanie, part of our steering committee, and we pulled that together. Since we started that, we’ve been doing metrics. I’m anxious to hear what everybody does for their metrics. You know the monitor it because it’s not just this is the right metric and it will tell you everything that’s really hard to come by. We’ve also now expanded to our Children’s Crittenden Children’s Center, which is our child, not Olesen Hospital. They’re piloting it now. Our real goal is to get IT system wide and have all the entities have it and then expand into our providers. And I’m glad you brought up the PSO because there is a concern about you know, privilege and suppressing information so that it doesn’t get out.”

3. Creating a steering committee for healthcare worker suicide prevention

“The other thing we did was the steering committee for the overall system, one to look at how we expand and what other suicide prevention measures we put in place for our employees.

This is the precursor to the Betsy Lehman Center is MITSS, the medically induced trauma support services. They have a toolkit you can download and very kind of quick reference kind of sheets and access to a lot of other different places like University of Missouri is a another one for people that just need a quickie reference kind of thing. We actually contracted with MITSS, medically induced trauma support services with Linda Kenney who is a speared head of that program out of the Betsy Lehman Center. We started having conversations about our implementation process.”

4. Using the Agency for Health Research and Quality (AHRQ) Safety Survey to assess peer support groups

"I think what I wanted to know is what people used as a metric to track the success or failure of their groups. **What we did was adding some questions into our AHRQ safety survey to help capture some of that information because we do that every 18 months. But I think we were looking at some sort of a wellbeing survey to just kind of survey the team to see. You know how we feel? How we're doing and kind of do those on an interval period of time.** But I'm interested to see what everybody's metrics are and how they arrived at that and if it's really helping to tell the story of their program, I like to tell the story of our program through stories. You know, like when you do intervene with a patient, not patient. I'm always patient oriented. When you intervene with the staff member, I did that on behavioral health, I had a staff member that was involved in a workplace violence event. And it really started to shake her about two days in and we were just talking about the event."

5. Peer support leaders have a visual on their badges to signal they are safe to talk with

"**One thing we did we did a visual on a name badge and I'm not a peer supporter so. So you can't see that little heart on my badge. But if you're a peer supporter, we give them all green hearts to put on their badges so that if somebody's just new to the organization and they see somebody with a green heart, they just can go right up to them and initiate a conversation.** I'm very interested in how people are doing the rounding. I think rounding is where we need to go, that proactive reaching out to people because people just are so busy. They don't want to reach out."

Employee Assistance Program (EAP) Focus Group Hospitals and Systems

Bryan Health, Lincoln, Neb.

1. Conducting employee engagement surveys to assess usage of EAP services

“You know I would classify it as system wide it it’s we had a you know I’ve been here 25 years and we had a EAP program that I would consider as kind of a homegrown EAP program that had contracts with a lot of other companies and different things but about four or five years ago. **Through just through our employee engagement survey, we had a lot of different feedback about our benefits and in different things and some of the feedback was that, you know, we maybe we needed to look at expanding some of the choices that are EAP program offered**, you know like financial and some of the some of the other pieces.”

2. Utilizing apps to access EAP services and partnering with external companies for additional EAP services

“But I would say that their goal is in our goal for the Pew program is 4 employee employees, emotional Wellness, but also for our management and leadership support in that you know we want to get employees to EP that needing it to EP but also for our leadership. **The technology support with our EP and we have a program where we just started and it’s through the EP and it’s called Supportive (app name) where it’s like an online chat. So you know I could still reach out and get a EP counselor, but if I’m on my way to work and I’m feeling really nervous about coming to work, I can get onto this app on my phone and right away I get connected to peers and other places Come and talk through my anxiety or my depression and like instantaneously and get into a small group of five to eight people and we can share our concerns and then get on to work.** And that’s really taken off. People would really liked like that.”

“It is an external company, so it’s not within Bryan. They’re not our employees, but it’s contracted through the hospital and our HR department you know is the entity who decides and works with the EP program. We are a nonprofit hospital and you know our leadership strongly believes in employee Wellness and we do actually. Have an onsite Wellness program. We do have a Wellness coordinator and then we have a therapist who works with that Wellness coordinator. There’s two of them. A lot of times what happens is letter comes, employees will reach out to the Wellness program and they’ll maybe start like an exercise program and they might connect with that therapist for one or two kind of Wellness sessions. It’s not really. Package there up to where we have kind of the Wellness because we have our Wellness Center which is what we call life point which is our exercise center that we have an onsite that we encourage employees to join and be a part of and exercise and do those types of things.”

3. Conducting QPR Training, mental health screenings, and developing a mental health emergency room

QPR Trainings

“We decided to train all of our leaders on QPR. So we brought, we devoted one of our leadership meetings and did all of our senior leaders or directors or managers or supervisors. **Everybody was trained on QPR and then for the rest of the hospital we knew it would be, you know, more difficult to make it mandatory for all nurses and everybody.** So we made it as an option. We made it optional and we offered QPR trainings during the various shifts and suggest that everybody, you know get QPR trained but for the leaders then what we did is I worked with our HR director and we developed a procedure on suicide prevention. **And basically what the procedure is is if you are an employee or leader and you run across another employee who you’re concerned about, they’re showing any signs and symptoms of suicide that you go to your, your leader, you go to a leader and let them know that, hey, I’m concerned** about Dave, these are the signs and symptoms he showing that leader will pull that employee in conduct.”

Mental Health Screenings

“**We have our online screenings and we we’re seeing those numbers go up every year were the community and staff then go online and take a pre alcohol or depression or anxiety or psychosis or whatever type of screening and then it’ll tell him where whether or signs and symptoms are there.** So you know those are good things and we put up signs in our parking garages several years ago as part of a initiative and now we have those up communitywide. We have an outpatient clinic for both counseling and substance use on site. And we’re seeing numbers go up from employees utilizing those services. Insurance. If the, you know, it’s all set up in a way that it benefits them to get into services here that they’ll, they’ll come here. But then I also have the same concern. Is this the quick access with with the where things are going. We’re just having such a hard time with getting folks in even with him like you said with the VAPIP you call and say.”

Mental Health Emergency Room

“One thing that we did several years ago that that’s that really worked well and has continued to work is in part of it. And I think it would work even if we didn’t have a mental health emergency room. But you know, so I guess I have to little context. So we have a in a mental health. So it’s an emergency room within an emergency room. So we have a mental health nurses and social workers 24 hours a day within our main emergency room and we see roughly between 6 and 7000 people a year that come through in a mental health crisis. And then from there we assess and then they get up. We happen to have a Garrett Lee Smith or SAMHSA Grant several years ago. **And one of our goals was to blanket the state with QPR training that was kind of our gatekeeper training. We wanted everybody to know how to. What to do if they ran into somebody who is suicidal?** And so we use the question, persuade and refer training the QPR training and so we had and we have a College of Nursing here at Brian and one of our nurse. at that point you can either refer to EAP, but if it’s an emergent situation and then they would get them to our mental health emergency room and then the hospital would cover that evaluation, employee wouldn’t have to pay for that. We would get them to the mental health emergency room, we would evaluate them to determine if they needed to be hospitalized or what disposition that they needed.”

“We have one for employees and here’s the process to follow and who to refer to and managers you need to call HR to let them know that you know, hey, I’m sending somebody over to the emergency room and we have that process down, and that’s where that’s worked out really well. So that’s a process that we put into place and then with COVID and everything just kind of reminding everybody because you know, we’re really concerned and now with the you know with things getting better, that’s a good thing.”

4. Advice on having a successful EAP and notes on EAP funding

“I would say think outside the box. We have peer specialists on staff and that started with a grant that we had years ago. These are individuals with lived and then I’ll health experience and the state under Nebraska has a certification. You can be a certified peer specialist.”

“And that’s how EAP is funded internally. We also have about 45 external contracts that you know definitely helped to bring in some revenue to support EAP. There are also a build a PPM, so that’s basically how it’s funded. And it’s supported, obviously it’s supported strongly by senior leadership within the system.”

1. Securing EAP grant funding

“One of the other things that we did that we’re really proud of that’s been a smashing success is we developed a grant program called the Spreading Joy Grant initiative and it took a I got the Medical Group to support \$12,000 and each quarter we give out three, \$1000 grants to any team who wants to apply for a grant that must have. Outcome measures and they must let us take pictures of whatever it is that they do, and it must be with the core purpose of spreading joy. We are now on our third no 4th, 3rd cycle and we have probably had total over 600 applications from across the organization, across the hospital and it’s a really great way. That’s not, you know, \$12,000 is really.”

“One of the programs was the chief resident and internal medicine applied for a grant to do a Wellness day for the residents, which included being pet therapy and included all this stuff that they did for the day and they wanted extra funding to help support it. And it was like a huge success. Another group applied for art supplies so that they could do a mural in the emergency room. That was a COVID centric health care workers. **They applied for a grant just so that they could have like a series of luncheons to build rapport, and we thought, you know what we agreeing with you guys, you have been undervalued. So let’s give you a grant.** So there’s fun, you know, just a variety of different groups. But it’s fun, really interesting to see on the creativity that has really emerged.”

2. Supplying a therapist dedicated to healthcare workers and developing a “Heal and Recovery” team to help healthcare workers process traumatic events

“EAP had a variety of different programs in batted in it in addition to just providing that individual support, we have the system team, which is our critical incident stress management team is embedded in EAP and run by EAP. We also in 2018 hired a therapist specifically for physicians, which I think was really novel and has increased utilization of our residents, fellows and faculty because she has, she’s my she’s act trained. She gets out there, she really gives practical advice, she gives a lot of presentations, which I think people look at her and say she’s someone that I feel like I could. We really tried to I think improve access to break down those walls by having this person designated we also have a program called the Trust program which again is not novel a lot of places use the trust acronym for their peer support program and we have trust partners trained physicians.”

“We developed a heal and recover team, and there’s been several different interventions that have emerged throughout COVID that are also managed out of EAP one of them is something called peer processing groups. So a therapist in EAP partners with a leader in a particular team. Or you net and they sit down and I’m really process what people have just gone through and there’s a key emphasis on validating and normalizing peoples reaction and then kind of an introduction to this idea of post traumatic growth and what people can learn and how they can actually become stronger. And interestingly of, we’ve had a total of I think over 7000”

3. Conducting mental health first aid training, utilizing the Zero Suicide Program, and having peer support groups

Mental Health First Aid Training

“Another intervention that’s been really important is our Care CART initiative. We really got a lot of feedback, especially early on that people felt like how can you care from where you stood in the comfort of your home virtually like you’re not here with me. You don’t really know what it’s like to be me. **And so after kind of that first surge, we developed this Care card initiative local volunteer to push the care card are trained in psychological first aid and they go to all of the units throughout the hospital. There in the weeds with people they’re touching base with people. It’s marketed as a heal and recover strategy.** We have information about EAP and other mental health resources within the organization.”

Zero Suicide Program

“We have a really strong Zero Suicide program in behavioral health at Henry Ford. Just within our Department of Behavioral Health, we have a lot of Zero Suicide programming and interventions that go on within our department. Probably our most difficult or rate limiting step is that transition from EP to behavioral health.”

Peer Support Groups

“We also developed a buddy program called Stronger Together Buddy program. And I was really kind of behind that. It was based on that rent, the military they do about a type programs or battle buddies. **People make a commitment to text each other or call each other for a 12 week, 12 week period and then we send them a little tool kit that they get every eight Monday for those 12 weeks that has a different micro scale and different challenge for the week.**”

4. Building awareness for EAP services, having dedicated staff for EAP services, and understanding the needs of healthcare workers

“Building awareness is really, really key, providing opportunities for screening and self-assessment. **One of the things that we have done as an organization is we have the wellbeing index as a tool for self-assessment and there is a suicide dashboard on that that at least if people see that that is in the rad that that it. Immediately gives some information about resources where they could go up.**”

“So that might help improve utilization for physicians is to embed a clinician that’s just permanent positions into your EAP. One of the things that she’s done to that in addition to presenting is she frames that a lot around this idea of coaching. And **interestingly, people feel a lot more comfortable if she calls it coaching versus treatment. And since the services are free, I guess you could call it whenever she wants, but they really the residents go to her for coaching and that’s been, I think, more pally in a ball and it’s about better and it’s about last scary I think of suicide prevention program should have quick access.**”

“**They can have a psychiatric evaluation and determine the next level of care. So in addition to that quick access, you wanna have resources both internally and externally that can serve the population** because some people aren’t, you know, your housekeeping staff. Being admitted to our hundred beds psychiatric hospital but one of our surgeons might say, you know, I really don’t wanna go to Kingswood Hospital. Would be taken care of by one of your psych resident. You know, I would rather. And so we need to have. I think programs need to add those resources both inside and outside their health system and have those relationships be really robust.”

5. Advice on creating impactful EAPs and leveraging storytelling campaigns to raise awareness of EAP services

“My advice would be one size does not fit all and I think we need to have lots of different types of interventions. Be creative. No, that something might resonate with one person, but isn't gonna resonate with another person. So I think that there's a lot of different ways to kind of scratch at it and to be really open to all of these different ideas and know that people are going to meet it or come do it, you know.”

“And so working in collaboration with your marketing team allows you to write up stories about what people have done and it gets you a little bit of juice in terms of, you know, I think saying what the organization is doing to give back to the community, the healthcare community or health care worker community because at this point,”

Mercy Health System, St. Louis

1. Providing all hospital staff EAP services, understanding barriers EAP utilization, and raising awareness of EAP services

“All of eligible dependents and our EAP program allows anyone living in the employees home to access EAP services.”

Noted Barriers

“It's something that we've been challenged with. We'd like to see much more utilization and I'm hearing that that some physicians don't want to use the AP because it's being documented, even though it's in a proprietary, you know.”

“But also raising awareness internally to themselves at that people that people naturally have suicidal thoughts. Based on the stressors that they have going on in their lives.”

Appendix 2. Resources Referred to by Interview and Focus Group Participants

Table 1 lists selected resources listed by interviewed hospitals and systems. For an in-depth understanding of the hospitals and systems used these resources, refer to Appendix 1. An asterisk (*) indicates when multiple hospitals and systems mentioned the same resource or program.

Table 1. Select Resources mentioned during Interviews and Focus Groups

Resource Name	Brief Description	Resource Link
American Hospital Association (AHA) People Matter, Words Matter	AHA has launched a posted campaign that hospitals, systems, and partnering organizations can display to reduce stigma of mental health issues and care-seeking behaviors. Refer to Appendix 1, CHI Health Quotes for additional details.	https://www.aha.org/people-matter-words-matter
A brief history of clinician support and the “second victim” phenomenon	This YouTube video outlines how clinicians became the “second victim” in adverse patient outcomes and how this phenomenon affects the clinician’s mental health.	https://www.youtube.com/watch?v=bjndt5slM7k
Caring for the Caregiver Program*	Cited by multiple hospitals and systems as an effective program to support healthcare workers experiencing adverse events and other mental health effects on the job.	https://caringforthecaregiver.ucsf.edu/
Kate Spade Suicide Prevention Resources	Kate Spade’s brand compiled a resource list for suicide prevention, in light of Kate Spade’s recent death by suicide. The resources are specifically geared towards women and girls, but can be used universally.	https://www.katespade.com/social-impact/lp/
Marvin Tele-therapy	Tele-therapy company specifically geared towards healthcare workers. Refer to Appendix 1, Thomas Jefferson University & Jefferson Health Quotes for details on how their healthcare workers utilize Marvin platforms.	https://www.meetmarvin.com/
Mental Health First Aid (MHFA)*	Cited by multiple hospitals and systems, MHFA informs and trains participants on mental health and substance-use issues.	https://www.mentalhealthfirstaid.org/

MetroHealth “Healing Begins with Listening” Video	This video highlights the empathy and resilience culture of MetroHealth. Also showcases a diverse healthcare workforce.	https://www.metrohealth.org/racial-equity/healing-begins-with-listening
Orexo Therapies	Digital therapy used by Trinity Health for healthcare workers mental health care.	https://orexo.com/digital-therapies/
Psychological First Aid (PFA)*	Cited by multiple hospitals and systems, healthcare workers in interviewed hospitals and systems were trained in PFA. PFA acts as a crisis intervention framework that aims to stabilize/ meet the immediate needs of impacted individuals.	https://www.apa.org/practice/programs/dmhi/psychological-first-aid
QPR Training (Question, Persuade, Refer) *	Cited by multiple hospitals and systems, healthcare workers in interviewed hospitals and systems were trained in QPR Suicide Prevention. QPR is specifically tailored to preventing suicide ideation and attempts.	https://qprinstitute.com/about-qpr
Schwartz Rounds*	Schwartz Rounds are part of the Caring for the Caregivers toolkit. These rounds are done on a large scale focusing on one event or case that was emotionally impactful and recovering from the events.	https://caringforthecaregiver.ucsf.edu/schwartz-rounds#:~:text=Schwartz%20Rounds%20are%20grand%20rounds,to%20comments%20from%20audience%20participants
Stress First Aid (SFA)*	SFA training identifies and responds early to stress injuries specifically in healthcare workers and offers peer support in its training model.	https://edhub.ama-assn.org/steps-forward/module/2779767
Substance Abuse and Mental Health Services Administration (SAMSHA) Wellness Model	The SAMSHA Wellness Model provides a holistic framework that the interviewed hospitals and systems used to approach their wellness programs. This wellness model can be implemented in any setting, not just in healthcare.	https://mfpc.samhsa.gov/ENewsArticles/Article12b_2017.aspx
The Jed Foundation	Used by Oregon Health and Science University	https://jedfoundation.org/our-approach/
Zero Suicide Program*	The Zero Suicide program is a framework used to preventing suicides in healthcare workers. The program provides evidence-based tools and resources that healthcare organizations can use in preventing suicides among healthcare workers.	https://zerosuicide.edc.org/

Additional Hospital and Systems Shared Resources

The freely shared resources listed here by hospitals and systems are to benefit the CDC (Centers for Disease Control) Suicide Prevention among Healthcare Workers programs. Figure 1 displays Boston Medical Center Stress Continuum Model used for healthcare workers to share common language when discussing their mental health status. The Stress Continuum was created by their Employee Resilience Program (refer to Appendix 1, Boston Medical Center Quotes for more details on how they implemented the Stress Continuum). Figure 2 is a sample job description from Trinity Health of a Mental Health Advocate that works directly with healthcare workers to ensure their mental health and wellbeing (refer to Appendix 1, Trinity Health Quotes for more information on how their Mental Health Advocate role functions).

Figure 1. Boston Medical Center Stress Continuum Model

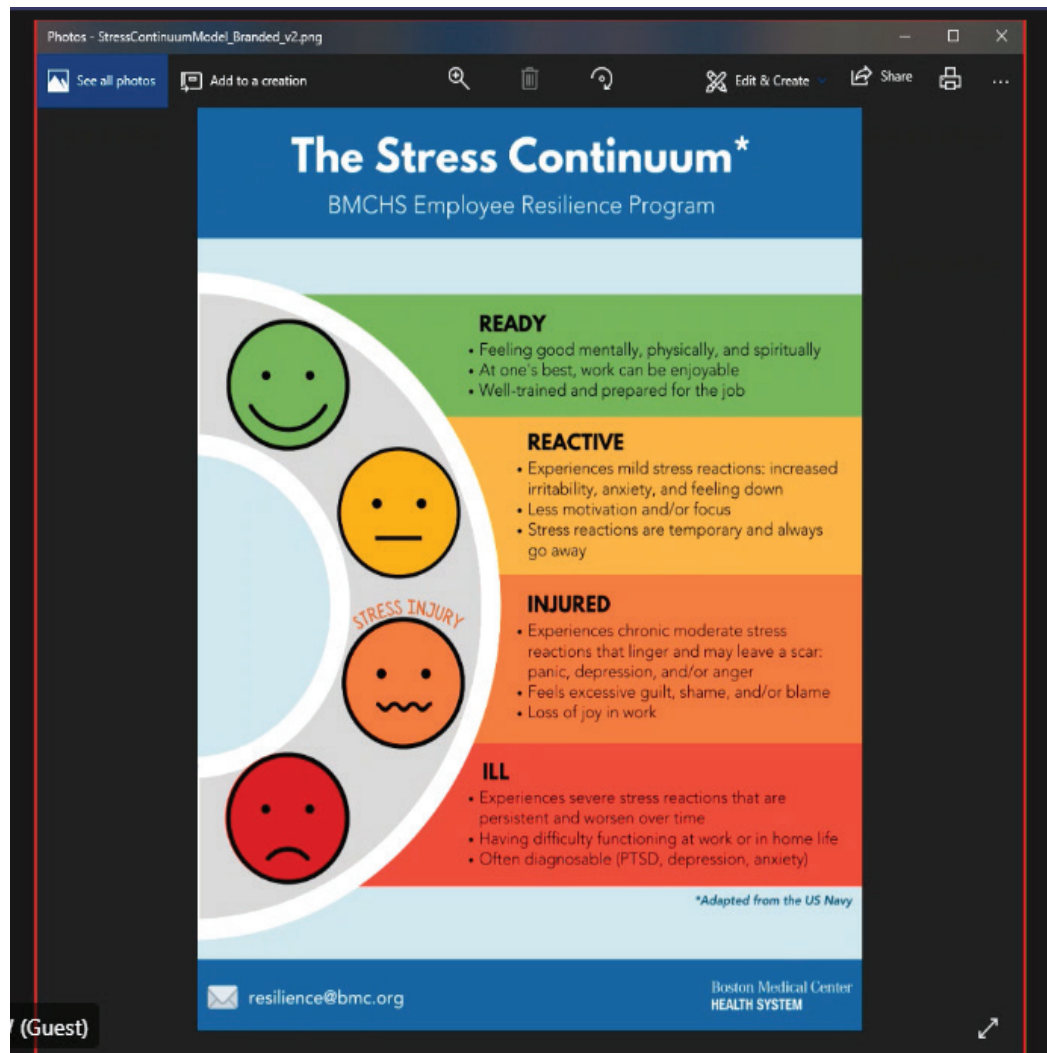


Figure 2. Trinity Health Mental Health Advocate Job Description Sample

ESSENTIAL DUTIES AND RESPONSIBILITIES

1. Advocacy
 - a. score: N/A
 - a) Identifies patient or staff needs
 - b) Changes or adapts programs as suggested by treatment team.
 - c) Alert to individual needs of patients and/or groups.
2. Participates in therapeutic milieu.
 - a. score: N/A
 - a) Develops therapeutic rapport with patients or staff individually
 - b) Interacts effectively
 - c) Uses the environment to facilitate constructive interpersonal relationships
 - d) Actively participates in plan of care/discharge planning throughout a patient inpatient stay
 - e) Staff is trained and competent on patient population that they serve.
3. Provide therapeutic services.
 - a. score: N/A
 - a) Individual (patient and staff) crisis intervention and/or therapy
 - b) Group crisis intervention
 - c) Family therapy as needed
 - d) Consultation services: ETC, acute care hospital and nursing home as needed
 - e) Complete hospital screen with creation of safety and/or discharge plan
4. Documentation of patient care.
 - a. score: N/A
 - a) Maintains records within established practice and guidelines for patient care
 - b) Provide documentation of patient progress toward established goals and discharge criteria.
5. Applies clear communication skills and properly processes information
 - a. score: N/A
 - a) Follows established lines of communication and authority for reportable information.
 - b) Reports needs to Department Manager follows chain of command.
 - c) Other duties as assigned.
6. Adherence to all of Trinity Health policies and procedures, including regular, timely, and consistent attendance, etc.

APPENDIX 1

Interview and Focus Group Protocols

Interview Protocol

HOSPITAL-BASED SUICIDE PREVENTION PROGRAM

Interview Questions

1. You indicated that your organization has a health care worker suicide prevention program in place. Please elaborate.
 - a. Is this program at the hospital or system level or both?
 - b. How did this program start? Does it have a charter/mission statement?
 - c. When did it start?
 - d. Does the program require funding? If so, where does the funding come from? Is it sustainable?
 - e. Who is the target audience? (Physicians, nurses, all staff, any ethnic group(s) or gender identity(s), etc.?)
2. Please tell us more about the day-to-day operations of the program.
 - a. Who are the key stakeholders/leaders from your organization that work on your suicide prevention program? What are their roles?
 - b. What is working well in your program so far?
 - c. Has your program encountered any barriers? If yes, please specify. How have you overcome these barriers?
 - d. How do employees perceive your program?
 - e. Do you believe that your program could be adapted to a different type of hospital? For example, if you were part of a large system, would a rural hospital be able to implement your program successfully? Why or why not?
 - f. Do you have any written documentation that you could share to enhance your answers?
3. How does your organization measure the success of your program?
 - a. Do you collect any process and/or outcome data? If yes, what are you measuring? How frequently are you collecting it?
 - b. If yes, could you/would you share the outcome data with us? Has the data been published?
4. What would an ideal health care worker suicide prevention program look like to you?
 - a. Do you think efforts need to be refined to address cultural, gender, organizational role differences and if so how/why?
5. If you could give one piece of advice to a hospital that is interested in implementing your suicide prevention program, what would that advice be?
6. What would you say to a hospital interested in pursuing suicide prevention work about the value and return on investment of having a suicide prevention program?

Closing Comments:

- What accomplishment are you most proud?
- Do you have anything else you would like to share?

- Do you have any questions?

Peer-to-Peer Support Focus Group Protocol

HEALTH CARE WORKER SUICIDE PREVENTION PROGRAM

Focus Group Questions

1. You indicated that your organization has a health care worker suicide prevention program in place that focuses on using Peer to Peer Support Programs as a suicide prevention tool. Briefly describe your program, including information such as:
 - a. Is your Peer to Peer Support Program system wide or local to your hospital(s)
 - b. Your program's goals and objectives
 - c. How the program started and when
 - d. Does the program require funding? If so, where does the funding come from? Is it sustainable?
 - e. Your target audience (Physicians, nurses, all staff, etc.?)
 - f. The key stakeholders from your organization that work on your program.
2. Please describe the day-to-day operations of the program.
 - a. What is working well in your program so far?
 - b. Has your program encountered any barriers? If yes, please specify. How have you overcome these barriers?
 - c. Are you collecting data and measuring the success of your program? If yes, how? And with what frequency?
3. What would an ideal health care worker suicide prevention program look like to you?
4. What is the best piece of advice you would give to a hospital that was looking to implement a suicide prevention program focused on the utilization of a Peer to Peer Support Program?

Closing Comments:

- What accomplishment are you most proud of?
- Do you have anything else you would like to share?
- Do you have any questions?

Employee Assistance Program (EAP) Focus Group Protocol

HEALTH CARE WORKER SUICIDE PREVENTION PROGRAM

Focus Group Questions

1. You indicated that your organization has a health care worker suicide prevention program in place that focuses on using the Employee Assistance Program (EAP) as a suicide prevention tool. Briefly describe your program, including information such as:
 - a. Is your EAP system wide or local to your hospital(s)
 - b. Your program's goals and objectives
 - c. How the program started and when
 - d. Does the program require funding? If so, where does the funding come from? Is it sustainable?
 - e. Your target audience (Physicians, nurses, all staff, etc.?)
 - f. The key stakeholders from your organization that work on your program.
2. Please describe the day-to-day operations of the program.
 - a. What is working well in your program so far?
 - b. Has your program encountered any barriers? If yes, please specify. How have you overcome these barriers?
 - c. Are you collecting data and measuring the success of your program? If yes, how? And with what frequency?
3. What would an ideal health care worker suicide prevention program look like to you?
4. What is the best piece of advice you would give to a hospital that was looking to implement a suicide prevention program focused on the utilization of an EAP?

Closing Comments:

- What accomplishment are you most proud of?
- Do you have anything else you would like to share?
- Do you have any questions?