



# Suicide Prevention

## Evidence-Informed Interventions for the Health Care Workforce

---

### Analysis of Two Surveys on Supporting Mental Well-Being and Suicide Prevention Among Health Care Workers

Development of this product was supported by Cooperative Agreement CK20-2003, funded by the U.S. Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health. The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC or the Department of Health and Human Services.

# Table of Contents

Background.....	3
Sample and Methods .....	3
Sample Characteristics.....	3
Methods.....	3
Quantitative analysis .....	3
Qualitative analysis .....	3
Key Findings .....	4
A. Initial Survey Key Findings (n=6).....	4
B. Final Survey Key Findings (n=158) .....	6
Conclusions .....	13
A. Programs and Strategies to Support Mental Well-Being and Suicide Prevention among Health Care Workers.....	13
B. Present Challenges .....	14
Recommendations .....	15
Appendix 1. Sample Quotes .....	16
A. Initial Survey .....	16
B. Final Survey.....	16
Appendix 2. Subgroup Analyses by Hospital Characteristics.....	20
Samples and Methods .....	20
Subgroup Analysis by Hospital Characteristics, Final Survey, Questions 1 through 5.....	20
Brief Summary of Findings .....	21
A. Subgroup Analysis Findings by Location (Rural vs. Urban).....	22
B. Subgroup Analysis Findings by System Membership (Health Systems or Hospitals within Health Systems vs. Independent Hospitals) .....	27
C. Subgroup Analysis Findings by Hospital Bed Size (Small vs. Medium vs. Large) .....	32

# Background

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. Because the two surveys asked different questions, they were analyzed separately.

## Sample and Methods

### Sample Characteristics

The roles of respondents were categorized into four types - Executive-Level, Director-Level, Clinical Staff, and Administrative Staff - based on the job title that respondents provided in the surveys. Respondents who did not provide a title were given a role of "None." Of the six respondents in the initial survey, half did not provide any information on their role, two were classified as having Executive-Level role, and the remaining respondent was assigned a Director-Level role. Of the 158 respondents in the final survey, the majority were classified as having either a Director-Level role (31.0%) or an Executive-Level (28.5%) role. Less common were clinical Staff (7.0%) and Administrative Staff (5.7%), and slightly over a quarter (27.8%) did not provide their role at all.

### Methods

#### Quantitative analysis

The survey questions fall under three types: yes/no, check-all-that-apply, or open-ended. Yes/no and check-all-that-apply questions were summarized using counts and/or percentages. For check-all-that-apply questions, the sum of percentages across all response options do not necessarily add up to 100 percent (and often exceed 100%).

#### Qualitative analysis

For check-all-that-apply questions (e.g., Question 1 in the final survey), respondents who chose the "other" option, were allowed to enter an open-ended response. Each open-ended response was examined to identify themes. In some cases, the themes were similar to the (non-"other") response options provided, and in some cases, new themes emerged.

For purely open-ended questions (e.g., Question 6 in the final survey), each response was examined to identify themes that emerged across all responses. Some respondents addressed multiple themes in their answers; therefore, the sum of frequencies of responses across all themes do not necessarily equal the total number of survey respondents. Respondents that did not fill in the open-ended questions or gave responses that are a variation of "no answers at this time" were marked as "no response stated."

As noted above, the initial survey questions were not comparable to the questions from the final survey. However, similar themes pertaining to improvement initiatives were found in both surveys. **The following sections provide key findings separately for each survey. Selected quotes from the responses to Questions 2 and 4 in the initial survey, and to Questions 6 and 7 in the final survey, are provided in Appendix 1.**

# Appendix 1. Key Findings

Findings from the two surveys are reported separately below.

## A. Initial Survey Key Findings (n=6)

**QUESTION 1.** *My hospital/health system is implementing an initiative with similar goals [to that] of the HEAR program, [and] yet different (Yes or No)*

Three respondents (50%) indicated they are implementing an initiative with goals similar to the HEAR program.

**Figure A-1. Frequency distribution of responses to Question 1 in the initial survey (n=6).**

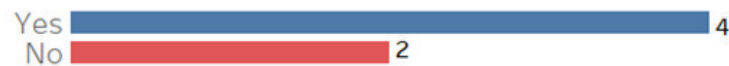


[QUESTION 2 responses were combined with Question 4 responses below]

**QUESTION 3.** *My hospital/health system has an initiative underway that is different from those described here: <https://www.aha.org/system/files/media/file/2021/03/In-playbook-companion-0321.pdf> (Yes or no)*

Four respondents (67%) indicated they have an initiative underway that is different from the playbook linked in the question.

**Figure A-2. Frequency distribution of responses to Question 3 in the initial survey (n=6).**



**QUESTIONS 2 AND 4.** *Open-ended questions, emerging themes on improvement initiatives that were underway but different from the programs indicated in Questions 1 and 3 above.*

When respondents were asked to describe their current improvement initiatives that were different from that of the HEAR Program (Question 2) or the other initiatives described [here](#) (Question 4), four types of improvement initiatives emerged:

- Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=3)

*“At the beginning of the pandemic (Spring 2020) Peace established an Emotional Support line for staff. The Emotional Support Line (ESL) was created by Peace Hospital for all [hospital name] staff and remains an active source for our employees. The ESL provides emotional support through active listening and help identifying and connecting employees to resources. In addition, we offer weekly, virtual mediation/mindfulness sessions.”*

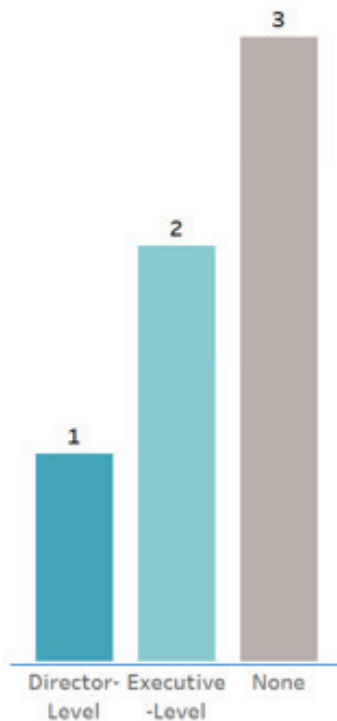
**-UoFL HEALTH - PEACE HOSPITAL**

- Offering mental health first aid training and adopting national-level healthcare worker mental health initiatives (Zero Suicide Program and Caring for the Caregiver) (n=2)
- Supplying dedicated online portals, apps, and emails focusing on mental health services for staff (n=1)
- Direct access to onsite mental health and wellness services, referrals, and crisis management (n=1)

**QUESTIONS 5-7.** *If you answered yes to either question, please enter your First & Last Name, Title & Organization, and Email & Phone*

As already noted above, respondents’ roles were categorized into four types: Administrative Staff, Clinical Staff, Director-Level, or Executive-Level. In addition, those who did not provide a role were assigned to “None.” Respondents who reported their roles in this first survey fell under either the Director-Level or the Executive-Level role.

**Figure A-3. Frequency distribution of roles assigned to respondents to the initial survey (n=6).**

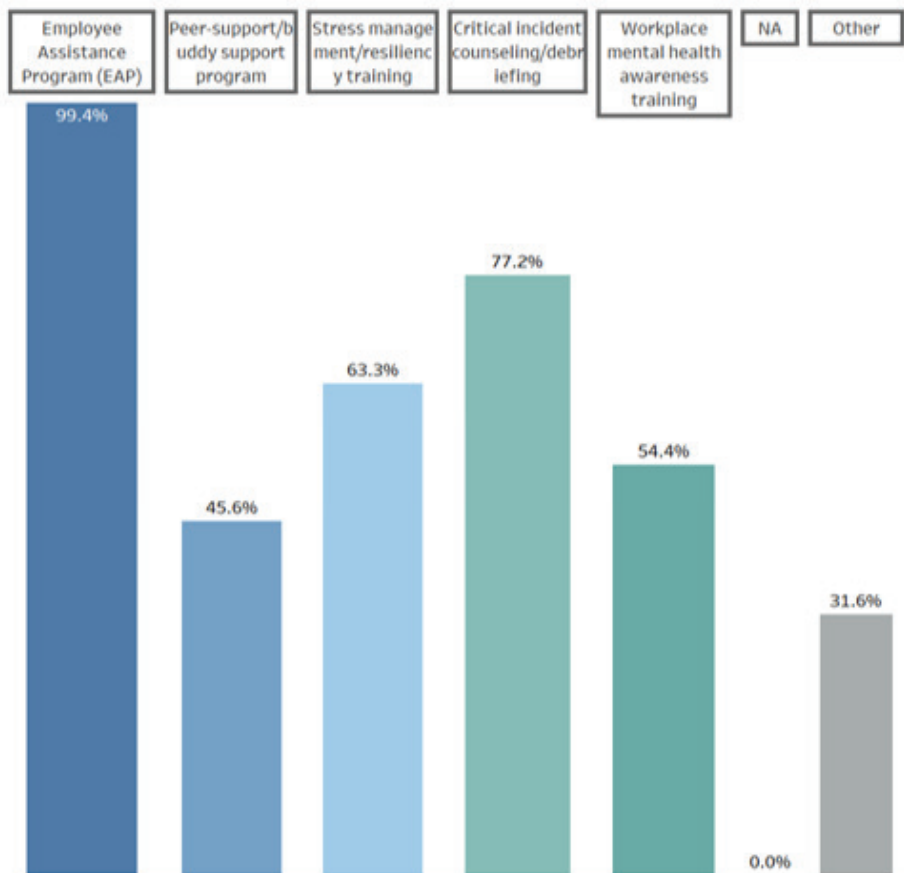


## Final Survey Key Findings (n=158)

**QUESTION 1.** *What programs does your hospital or health system have in place that are focused on preventing suicides in your workforce? Check all that apply.*

“Employee Assistance Program (EAP)” was easily the most frequently selected type of suicide prevention program, with nearly all 158 respondents (99.4%) selecting it. The next three most popular types of programs were “Critical incident counseling/debriefing” (77.2%), “Stress management/resiliency training” (63.3%), and “Workplace mental health awareness training” (54.4%). The least frequently selected option (other than “Other” and “NA<sup>1</sup>”) was “Peer-support/buddy support program” (45.6%).

**Figure B-1. Percentage of respondents selecting each response option to Question 1 in the final survey (n=158).**



Fifty of the 158 hospitals (nearly 32%) responded “other” to Question 1. When examining the “other” responses, many of the responses fell under the same categories as the above response options, however, new themes emerged outside of given response options (\* indicates emerging theme):

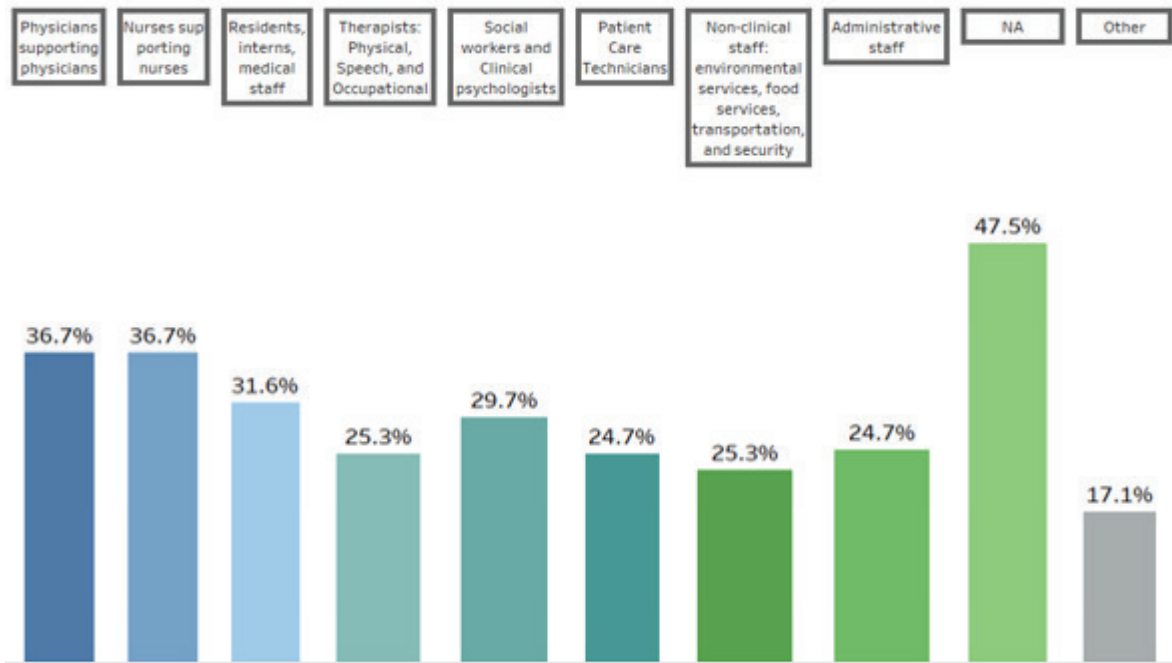
- Organization-run support program\* (n=24)
- Peer-support/buddy support program (n=8)
- Critical incident counseling/debriefing (n=8)
- Workplace mental health awareness training (n=7)
- Monitoring and surveying program\* (n=5)
- Employee Assistance Program (EAP) (n=1)

<sup>1</sup> Note that the meaning of the “NA” response option here is ambiguous. It could mean that the question is not applicable to the hospital or health system, “None of the above,” not yet implemented, or perhaps something else.

**QUESTION 2.** *If your hospital or health system has a Peer Support/Buddy Support program in place for encouraging peer mental health support, please share the types of clinicians and staff that are supported. Check all that apply.*

Almost half of the respondents selected “NA”<sup>2</sup> (47.5%). Excluding the “NA” responses, most frequently reported staff that were supported by Peer Support/Buddy Support programs were “Physicians supporting physicians” (36.7%) and “Nurses supporting nurses” (36.7%). The least frequent non-“Other” responses were “Patient Care Technician” (24.7%) and “Administrative Staff” (24.7%).

**Figure B-2. Percentage of respondents selecting each response option to Question 2 in the final survey (n=158).**



Twenty-seven of the 158 hospitals (17%) reported “other” to Question 2. When examining the “other” responses, many of the responses fell under the same categories as the above response options, however, new themes emerged outside of given response options (\* indicates emerging theme)<sup>3</sup>.

- All staff or mixed staff groupings\* (n=15)
- Physicians supporting physicians (n=1)
- Therapists: Physical, Speech, and Occupational (n=1)
- Social workers and Clinical psychologists (n=1)
- Patient Care Technicians (n=1)
- Administrative staff (n=1)
- No clinician or staff specified (n=7)

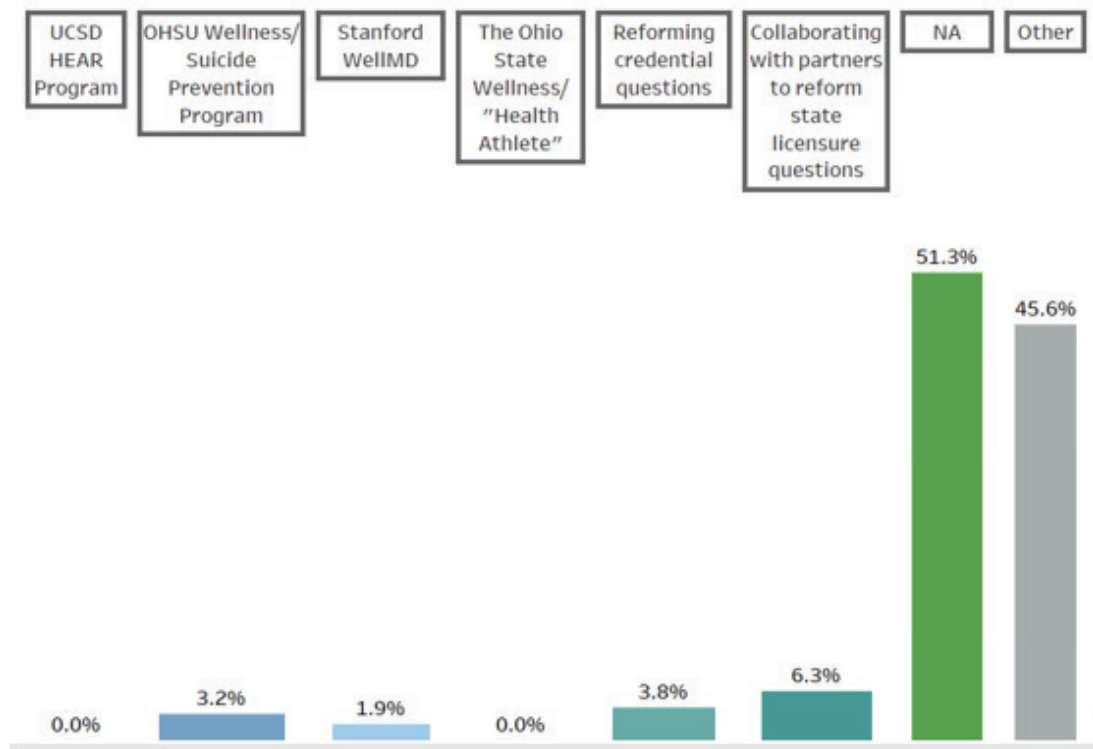
<sup>2</sup> Note that the meaning of the “NA” response option here is ambiguous. It could mean that the question is not applicable to the hospital or health system, “none of the above,” not yet implemented, or perhaps something else. In Question 2, two respondents selected “NA” but at the same time also checked additional choices: “Physicians supporting physicians” (N = 1) and “Nurses supporting nurses” (N = 1).

<sup>3</sup> Some respondents who chose ‘other’ did not specify any type of clinician.

**QUESTION 3.** Does your hospital or health system have one or more programs in place for encouraging health care worker access to mental health treatment and services? Check all that apply.

“NA”<sup>4</sup> (51.3%) and “Other” (45.6%) were the most selected responses; no more than 7 percent of respondents selected each of the remaining options. Among the non-“NA,” non-“ Other” response options, “Collaborating with partners to reform state licensure questions” was the most selected (6.3%). Two response options – “UCSD HEAR Program” and “Stanford WellIMD” – were not selected at all.

**Figure B-3. Percentage of respondents selecting each response option to Question 3 in the final survey (n=158).**



Seventy-two of the 158 hospitals (nearly 46%) reported “other”. When examining the “other” responses, many of the responses fell under the same categories as the above response options, however, new themes emerged outside of given response options (\* indicates emerging theme)<sup>5</sup>:

- EAP, wellness program and resources, mental health training\* (n=66)
- OHSU Wellness/Suicide Prevention Program (n=1)
- Stanford WellIMD (n=1)
- Collaborating with partners to reform state licensure questions (n=1)
- No program specified (n=3)

<sup>4</sup> Note that the meaning of the “NA” response option here is ambiguous. It could mean that the question is not applicable to the hospital or health system, “none of the above,” not yet implemented, or perhaps something else. In Question 3, two respondents selected “NA” but at the same time also checked the “other” option.

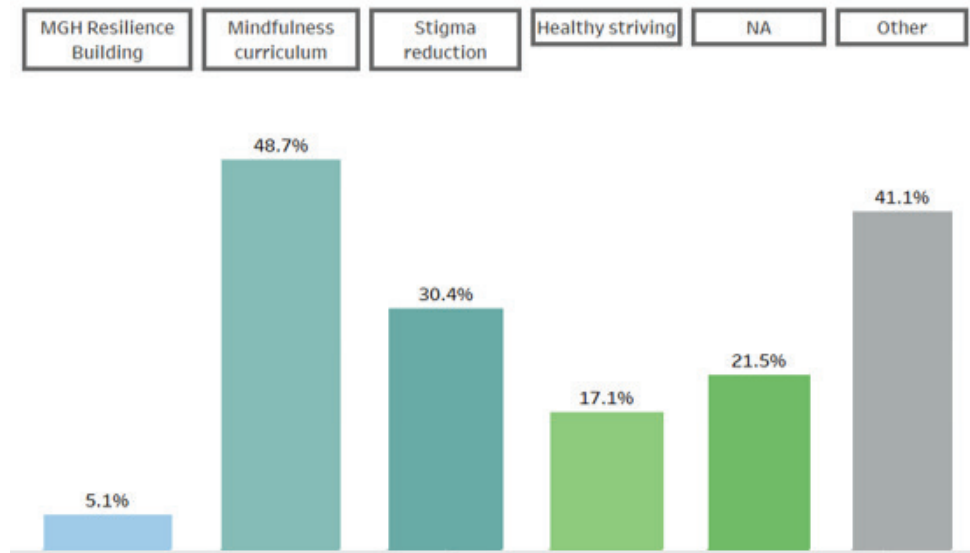
<sup>5</sup> Some respondents who chose ‘other’ did not specify any program.



**QUESTION 4.** *Is your hospital or health system implementing any programs to help health care workers maintain and grow resilience and purpose? Check all that apply.*

“Mindfulness curriculum” (48.7%) was the most frequently chosen response, “Other” (41.1%) ranked second, and “MGH Resilience Building” was the least frequently chosen (5.1%). A little over one-fifth of the respondents selected “NA”<sup>6</sup> (21.5%).

**Figure B-4. Percentage of respondents selecting each response option to Question 4 in the final survey (n=158).**



Sixty-five of the 158 (41%) hospitals reported “other.” When examining the “other” responses, many of the responses fell under the same categories as the above response options, however, new themes emerged outside of given response options (\* indicates emerging theme)<sup>7</sup>.

- Organization- run resilience building, mindfulness, and wellness program\* (n=52)
- Peer support, staff training, Schwartz Rounds\* (n=9)
- Stigma reduction (n=1)
- No program specified (n=3)

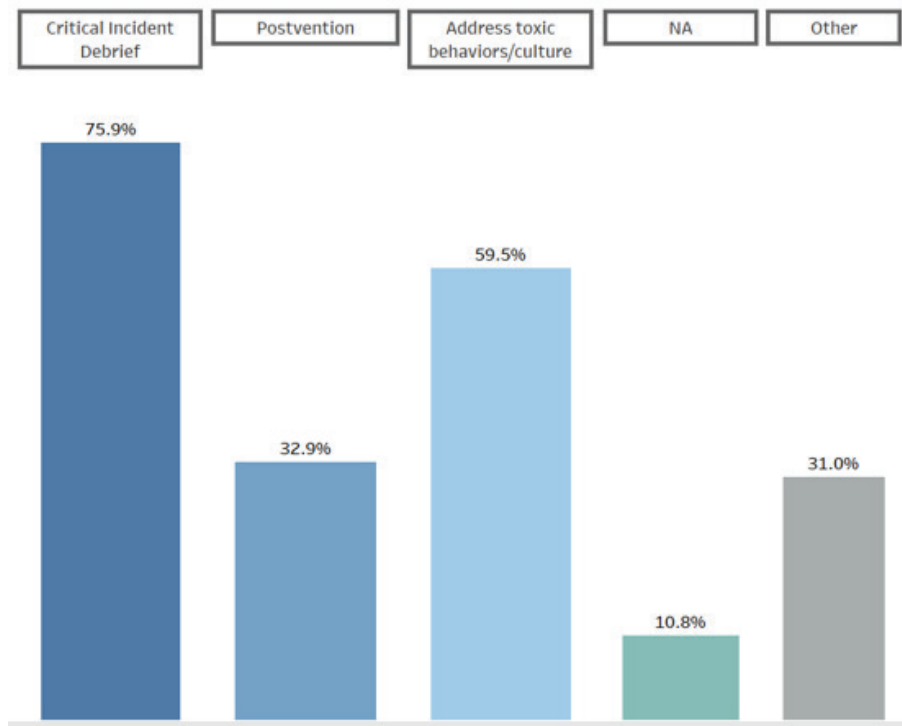
6 Note that the meaning of the “NA” response option here is ambiguous. It could mean that the question is not applicable to the hospital or health system, “none of the above”, not yet implemented, or perhaps something else. In Question 4, one respondent selected “NA” but at the same time also checked the “other” option.

7 Some respondents who chose ‘other’ did not specify any program.

**QUESTION 5.** *Is your hospital or health system implementing any programs to increase feelings of psychological safety for health care workers? Check all that apply.*

About 42% of respondents chose either “NA”<sup>8</sup> or “Other” but the majority of 158 respondents chose “Critical Incident Debrief” (75.9%) and “Address toxic behaviors/culture” (59.5%) each. “Post-intervention” (32.9%) was the least-chosen non-“NA,” non-“Other” response option.

**Figure B-5. Percentage of respondents selecting each response option to Question 5 in the final survey (n=158).**



Forty-nine of the 158 hospitals (31%) reported “other”. When examining the “other” responses, a few of the responses fell under two of the above response options, however, about 90% (n=44) of the ‘other’ responses fell under a new theme (\* indicates emerging theme)<sup>9</sup>:

- Psychological safety and crisis and mental health education/resources\* (n=44)
- Critical Incident Debrief (n=2)
- Post-intervention (n=2)
- No program specified (n=1)


<sup>8</sup> Note that the meaning of the “NA” response option here is ambiguous. It could mean that the question is not applicable to the hospital or health system, “none of the above,” not yet implemented, or perhaps something else. In Question 5, seven respondents selected “NA” but at the same time also checked the following options: “Critical Incident Debrief” (N = 2), “Post-intervention” (N = 2), “Address toxic behaviors/culture” (N = 2), and “Other” (N = 1).

<sup>9</sup> One respondent who chose ‘other’ did not specify a program.

**QUESTION 6.** *Is there anything else that you would like to tell us about the work to improve health care worker access to mental health services at your health system or hospital?*

Based on 158 participating hospitals' open-ended text responses, nine improvement initiative themes emerged:

- Establishing peer support and wellness groups and integrating wellness initiatives into workplace settings (n=34)
- Direct access to onsite mental health and wellness services, referrals, and crisis management (n=30)



*"We have offered virtual and in person office hours for staff to call into if they need to where they would instantly get connected to a therapist. This was outside of EAP and was for more immediate and brief support. We have done lunch and learns..., and some training on psychological safety.... We have thought and encouraged mindfulness and used these as part of a wellness incentive where staff can earn a mental health day for earning enough wellness points."*

**Fillmore County Hospital**

- Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=24)
- Offering mental health first aid training and adopting national-level healthcare worker mental health initiatives (Zero Suicide Program and Caring for the Caregiver) (n=21)
- Expanding Employee Assistance Programs (EAPs) to meet staff need and utilization (n=18)
- Monitoring, assessing, and surveying staff's mental health needs (n=11)
- Supplying dedicated online portals, apps, and emails focusing on mental health services for staff (n=9)
- In-person staff well-being check-ins and rounding (leadership rounds and Schwartz rounds) (n=9)
- Increasing diversity and inclusion across organization and resources (n=4)
- No response stated (n=54)

**QUESTION 7.** *Is there anything else that you would like to tell us about current opportunities and challenges supporting mental wellbeing and preventing suicide of health care workers in your health system or hospital?*

No current opportunities were specifically stated in the responses to Question 7, but hospitals explicitly stated some challenges. Based on 158 participating hospitals' open-ended text responses, seven themes of challenges emerged:

- Establishing mental health service infrastructure for staff (n=29)
- Limited staff engagement, resources, funding, and barriers to developing organizational policy (n=28)



*“Team members, particular in critical care, are somewhat used to dealing with death and dying. However, the recent pandemic added layers they were not accustomed to such as the death of our own staff and staff families, young patients and perinatal patients. Additionally, our workforce tends to be younger in age and we are concerned they don't have the life experience or emotional maturity to deal with this kind of thing. We have convened a taskforce consisting of unit leadership, organizational development, Magnet program coordinator, and spiritual care to make this work a priority in 2022.”*

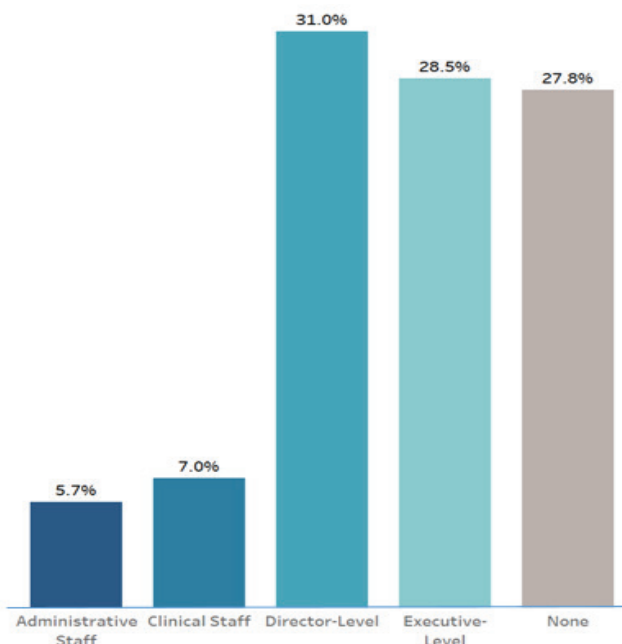
**AdventHealth Tampa**

- Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=25)
- Stress and burnout, staffing shortages due to COVID Pandemic (n=24)
- Increasing accessibility, availability, and higher utilization of EAP and mental health resources (n=14)
- Ensuring psychological safety and privacy with receiving mental health services (n=9)
- Insufficient time for staff training around mental health issues (n=6)
- No response stated (n=53)

**QUESTION 8.** *We would like to connect and follow-up with you on this topic, please leave your Name, Title, Organization, and Email below.*

All respondents who provided a role were assigned logically to one of four role groupings: Administrative Staff, Clinical Staff, Director-Level, or Executive-Level. Those who did not provide a role were assigned to the “Missing” role grouping. In this final survey, Director-Level and Executive-Level respondents made up over half (59.5%) of the 158 respondents.

**Figure B-6. Frequency distribution of roles assigned to respondents to the final survey (n=158).**



# Conclusions

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. Based on the survey findings from the 158 hospitals and health systems that responded to the final survey, we draw some conclusions below, separately for these two topics. Because the respondents volunteered, they may not necessarily be representative of all U.S. hospitals and systems. Hence, these conclusions are not necessarily generalizable beyond the responding sample.

## A. Programs and Strategies to Support Mental Well-Being and Suicide Prevention among Health Care Workers

Hospitals and systems are implementing diverse strategies to improve access to mental health services for their health care workers.

### 1. Improvements in Accessing Mental Health Services

- *Employee Assistance Programs (EAPs) are the main strategy for implementing mental health services and suicide prevention within the hospital setting (Final Survey, Questions 1 and 3).*
  - Expanding the EAP to include additional mental health services proved to be beneficial to the mental health and well-being of their health care workers. Some hospitals' approach incorporates more visibility to existing programs through the EAP by email, intranet posts, and apps, hosting well-being seminars, and word-of-mouth promotion.
  - Other strategies employed, in order of popularity, include critical incidents counseling and debriefing, stress management and resiliency training, and workplace mental health awareness training.
- *Organization-created programs specifically tailored to the needs of health care workers are more prevalent than nationally recognized programs like UCSD HEAR Program, OHSU Wellness/Suicide Prevention Program, Stanford WellMD, and the Ohio State Wellness/"Health Athlete" (Final Survey, Question 3).*
  - Respondents noted being unfamiliar with programs like UCSD HEAR Program, OHSU Wellness/Suicide Prevention Program, Stanford WellMD, and the Ohio State Wellness/"Health Athlete" and noted a desire to learn more about these programs.
- *Creating spaces and programs that are geared specifically towards a hospital's unique challenges – two emergent themes – have been impactful in improving overall mental health well-being within health care workers (Final Survey, Question 6).*
  - Taken together, direct access to onsite mental health services, referrals, and crisis management target culture change and ensure direct access to care removes larger barriers to accessing mental health services.
  - Monitoring, assessing, surveying staff's mental health needs (using recognized survey instruments like PsySTART, Mayo Well-being Index Survey), and conducting in-person staff well-being check-ins and rounding allowed hospital and health care system leadership to examine the unique needs of their health care workers and provide specific resources needed.

### 2. Growing and Maintaining Resilience, Purpose, and Psychological Safety

- a. Peer support and wellness groups were the most utilized for improvements to health care workers' mental health and well-being and suicide prevention (Final Survey, Questions 2 and 6).
  - Physicians supporting physicians, nurses supporting nurses, and residents, interns, and medical staff supporting one another were the most popular forms of peer support groups.

- Establishing peer support and wellness groups and implementing wellness initiatives into the health care workers' days were especially important strategies in creating an organizational culture that destigmatizes mental health needs and builds resiliency.
- b.** *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).
- Interweaving multiple layers of support helps to successfully create an overall culture that promotes mental health and well-being programs and processes like Schwartz rounds, Caring for the Caregiver, Mental Health First Aid and Zero Suicides Program into existing mental health training and awareness programs created and offered by the hospitals.

## B. Present Challenges

1. *One challenge is creating a mental health services infrastructure for hospitals that are starting on the journey towards improving mental health and well-being amongst health care workers (Final Survey, Question 7).*
  - a.** Limited engagement in existing services, limited funding and resources, and barriers to organizational policy have been challenges, especially as the COVID pandemic is creating burnout and staffing shortages.
  - b.** The major barriers are not having enough time to access services, limited policy development/ leadership buy-in, and health care worker burnout and staffing shortages.
    - The COVID pandemic affected health care workers' mental health well-being and access to services, one respondent summarizes,

*"You do not have enough time! Working in health care, ALL LEVELS is life draining. I have worked in this industry for 33+ years and I am hanging on by a thread. What you are seeing with COVID is the straw that broke the camel's back! The environment and culture in nearly every healthcare organization is TOXIC. I've tried to make it my personal mission, as a Sr. Leader, to break this cycle but we're just too far in. [...] We are (always have been) reactive vs proactive. We need to stop trying to put a Band-Aid on everything. Offering "services" to address the mental health and well-being of staff is a Band-Aid. Until the cultures and underlying issues within organizations can be fixed, people will continue to leave healthcare. It's not worth the fight anymore. Access to MH services is a temporary fix (if a fix at all) as it will be "undone" once they have to return to reality (their job)."*
2. *Hospitals are rebounding from intensive workloads and balancing the mental health and well-being of staff (Final Survey, Question 7).*
  - a.** Finding the right balance and appropriate programs is difficult, especially since the EAP has traditionally been the only existing infrastructure (and often underutilized at that).
  - b.** Hospitals are attempting to bolster existing programs and create an organizational culture that improves health care workers' mental well-being.
  - c.** Ensuring psychological safety and allowing sufficient time for staff to engage in mental health services remains a challenge that needs systematic addressing.

# Recommendations

Based on the survey responses of the 158 hospitals and health systems that responded to the final survey, we offer the following recommendations. This sample is made up of voluntary participants and may not be representative of hospitals and health systems nationwide. Hence, similar to our conclusions, these recommendations may not be generalizable beyond the responding sample.

- a.** Since EAPs are listed as the most commonly available and used resource, expand EAPs to include direct onsite mental health services, referrals, and other mental health resources and training. The expansion of the EAP should be promoted through the most visible means (emails, online intranet portals, apps) when applicable.
- b.** Evaluate existing mental health infrastructure using recognized survey instruments and indexes (e.g., PsySTART, Mayo Well-being Index Survey) or utilize human resources and/or senior leadership surveillance on healthcare worker well-being. Surveying health care workers and standardizing metrics towards health care workers' mental well-being is important for hospital leadership to understanding the specific needs of their workers and taken account of what services are underutilized.
- c.** Use Schwartz rounds, Caring for Caregivers, Zero Suicides, and mental health first aid programs to build resiliency and mental health training. Hospitals wish to use more national-level programs and techniques, and need designated personnel, dedicated resources, and policies to support mental health services implementation.
  - Hospitals are looking for standardization on creating an organizational culture that destigmatizes accessing mental health services and build resiliency. However, unawareness or lack of frameworks or best practices leaves hospitals to create their own mental health and wellness programs. Many hospitals are curious about what other hospitals are doing in these areas.
  - National-level strategic playbooks on implementing mental health training were listed desires in respondents. Seminars, playbooks, and forums with other hospitals and their work around improving mental health and well-being among health care workers was listed as an aspiration.
- d.** Ensure that staff have the available time to access mental health services during their working hours and create a system within teams to provide ample amounts of coverage. (This might prevent overwork in other staff when a team member accesses mental health services.)

# Appendix 1. Sample Quotes

## A. Initial Survey

**QUESTIONS 2 and 4.** *Describe your initiative/ themes on improvement initiatives*

- **Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=3)**

“At the beginning of the pandemic (Spring 2020) Peace established an Emotional Support line for staff. **The Emotional Support Line (ESL) was created by Peace Hospital for all [hospital name] staff and remains an active source for our employees. The ESL provides emotional support through active listening and help identifying and connecting employees to resources.** In addition, we offer weekly, virtual mediation/mindfulness sessions.”

- **Offering mental health first aid training and adopting national-level healthcare worker mental health initiatives (Zero Suicide Program and Caring for the Caregiver) (n=2)**

“... **delivering the Caring for the Caregiver: Implementing RISE program, which has been designed to help organizations provide immediate, confidential psychological first aid and emotional support to second victims by utilizing trained volunteer Peer Responders.** Based on the RISE (Resilience in Stressful Events) program developed by the Johns Hopkins Armstrong Institute for Patient Safety and Quality, the **Caring for the Caregiver: Implementing RISE program consists of two training days (leadership and peer responders), coaching support, and all of the materials necessary to set up and sustain a peer support program at any healthcare organization.**”

- **Supplying dedicated online portals, apps, and emails focusing on mental health services for staff (n=1)**

“Online support group for frontline workers”

- **Direct access to onsite mental health and wellness services, referrals, and crisis management (n=1)**

“... **involved in providing educational opportunities for leaders to assist them with their own self-care as well as the care issues (mental health, resilience, burn-out) for their staff.** We are doing this through a “Compassionate Leadership” certificate program.”

## B. Final Survey

**QUESTION 6.** *Is there anything else that you would like to tell us about the work to improve health care worker access to mental health services at your health system or hospital?*

- **Establishing peer support and wellness groups and integrating wellness initiatives into workplace setting (n=34)**

“A pilot peer support program was implemented summer of 2020. Early 2021, the program was given approval for facility-wide expansion. The program is an evidence-based model based on the University of Missouri Healthcare’s ForYou program. **A survey distributed to the pilot group showed 80% desired a peer support program for emotional support following adverse**



**events.** A training program was developed along with the EAP director and converted to virtual platforms. Although the program is still in early development, utilization has exceeded initially projections. I would love to share more about this wonderful work; I often comment that I can talk all day about second victims and peer support.”

- **Direct access to onsite mental health and wellness services, referrals, and crisis management (n=30)**

**“We have offered virtual and in person office hours for staff to call into if they need to where they would instantly get connected to a therapist. This was outside of EAP and was for more immediate and brief support.** We have done lunch and learns on resilience, pandemic fatigue, and burnout, and have in a few departments done some training on psychological safety, including offering an anonymous survey where staff answered questions about how safe or unsafe, they felt on their team and then reviewed those and used them as a quality measure. We have thought and encouraged mindfulness and used these as part of a wellness incentive where staff can earn a mental health day for earning enough wellness points.”

- **Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=24)**

**“The well-being of the healthcare workforce depends on the commitment in an organization to a culture that values and respects all employees, recognizes the complex relationship between employee stress and organizational demands,** has a process to integrate a wide range of organizational programs and strategies to address employee and organizational stress across a continuum of stress responses, and values leaders learning from all employees. Occupational demands can create a range of stress injuries associated with burnout, trauma exposure, loss, and moral distress. Each of these sources of stress injury requires different approaches and resources for assessment and intervention. ”

- **Offering mental health first aid training and adopting national-level healthcare worker mental health initiatives (Zero Suicide Program and Caring for the Caregiver) (n=21)**

“It’s important to also support leaders and give them the tools they need to recognize their own stress and role model where to go for help. **Training leaders in psychological first aid is also critical to giving leaders the tools they need to support others.**”

- **Expanding EAP to meet staff need and utilization (n=18)**

**“There is a back log as all know for longer term MH. Our EAP has implemented a longer session model to support team members as they await access for long-term counseling.** We have also created sessions to remote into team meetings and build resiliency. Our organization also has created a Compassion Circle curriculum offered to up to 10 team members over the course of 6 weeks now led by EAP and chaplains. We also have provided PFA and Peer to Peer support training modules.”

- **Monitoring, assessing, and surveying staff mental health needs (n=11)**

“We are actively striving to meet the needs of our healthcare workers. We collaborated with a researcher from UCLA last year at the start of the pandemic and **used a recommended survey instrument called PsySTART to assess the experiences and levels of distress our HCWs were under.** We used this at regular intervals to follow/track experiences and where support was needed. ”

- **Supplying dedicated online portals, apps, and emails focusing on mental health services for staff (n=9)**

“The myCare website was developed to streamline well-being resources and make them available/accessible all in one place. **There is an Internal myCare site behind the Google Firewall that has a deep dive into resources. There is an External myCare site on [hospital website], outside of the Google Firewall, for those who may have barriers to logging into Google.** The myCare site is accessible through the Wysa App, and you can learn about the Wysa App on the myCare website. Both can be a “front-door” to our Well-Being Resources.”

- **In-person staff well-being check-ins and rounding (leadership rounds and Schwartz rounds) (n=9)**

“**We round frequently on staff to monitor the level of stress and fatigue.** We emphasize celebrating our wins with patient recovery or organizational results (trying to focus on the worthwhile work). We have offered flexible schedules that allow for more work/life balance. We have provided grief counseling after critical events.”

- **Increasing diversity and inclusion across organization and resources (n=4)**

“Our Office of Inclusion, Diversity and Health Equity offers monthly lunch and learn sessions that **focus on IDE-related topics that allow for productive dialogue thereby facilitating an environment/culture of psychological safety for all employees.**”

**QUESTION 7.** *Is there anything else that you would like to tell us about current opportunities and challenges supporting mental wellbeing and preventing suicide of health care workers in your health system or hospital?*

- **Establishing mental health service infrastructure for staff (n=29)**

“A barrier has been that much of this work/interventions are led by MDs and PsyDs - **other disciplines at times are hesitant to reach out to someone who is not of their same discipline - particularly for more group support/interventions.** We have a large system that spans our state, a system driven program has had limitations in understanding the unique challenges/needs that may exist at entities outside of our central SOM/hospital - particularly those that may be located in more rural/underserved areas and face a different compliment of needs.”

- **Limited staff engagement, resources, funding, and barriers to developing organizational policy (n=28)**

“**We’re not fixing the problems.** You can provide all the meditation, massage, quiet rooms, counseling, support staff, medication, psychologists, psychiatrists, ARNPs, MSWs, CBT, policies, trauma informed care...you want **but until the “politics” and actual organizational issues are fixed you will have nothing and no one.** If you couldn’t tell by now, I’m disgusted, fed-up, frustrated and just want out of this industry but where do I go?”

- **Creating organizational culture that destigmatizes mental health needs and builds resiliency (n=25)**

**“There are very inappropriate expectations for health care workers in the area of Behavioral Health.** We have high expectations for volumes of patients served, little to no time to debrief or refocus before moving on to the next patient. **The “industry standards” for providers are not conducive to excellence in patient care nor promotion of good emotional health of our providers.** Gone are the days of a PCP knowing their patients and taking the time to listen to them, with the current demands for all types of care, providers may often end their day feeling helpless, overwhelmed, and ineffective.”

- **Stress and burnout, staffing shortages due to COVID Pandemic (n=24)**

“Team members, particular in critical care, are somewhat used to dealing with death and dying. However, **the recent pandemic added layers they were not accustomed to such as the death of our own staff and staff families, young patients and perinatal patients.** Additionally, our workforce tends to be younger in age and we are concerned they don’t have the life experience or emotional maturity to deal with this kind of thing. We have convened a taskforce consisting of unit leadership, organizational development, Magnet program coordinator, and spiritual care to make this work a priority in 2022.”

- **Increasing accessibility, availability, and higher utilization of EAP and mental health resources (n=14)**

**“One challenge is that many staff and physicians are resistant to investing more time than their scheduled shift to join groups. Others feel they don’t need to engage in such practices - they can tough it out.** Which works out with predictably mediocre results until it doesn’t work anymore... and they subsequently self-insulate from support. The folks with the most intrinsic awareness of their need for ongoing self-care and structured sharing are the most likely to seek it out, but are often in lesser comparative need, since their existing propensity for doing the difficult work of the self usually carries over too many aspects of life.”

- **Ensuring psychological safety and privacy with receiving mental health services (n=9)**

**“Employee occupational stress injuries are major problems that can undermine safe quality care, professional and personal performance, job satisfaction, and retention.** [Hospital name] has occupational stress interventions that addresses both systems and individual occupational challenges while promoting the capacity to engage in with the complex demands of delivering safe high-quality care. **Early recognition of stress injury (behaviors that indicate change in function, altered coping, role distress, or increased use of maladaptive strategies) by peers and leaders is critical to reducing stigma and connecting team members with needed support.** Suicide, substance abuse, or unprofessional behavior are only a few indicators of stress injury. An approach that addresses the broad range of stress injury behaviors is needed so as to create an effective psychological safety net for the entire workforce.”

- **Insufficient time for staff training around mental health issues (n=6)**

**“Allowing healthcare workers to feel they have the time and space to access our programs has been challenging.** Adequate funding for well-being programs has also been challenging in the current healthcare climate.”

# Appendix 2. Subgroup Analyses by Hospital Characteristics

## Samples and Methods

To glean insight into whether responses to the five questions (Questions 1 to 5) in the final survey differed by type of hospital, analysis was further stratified based on three hospital-level characteristics from the 2020 AHA Annual Survey<sup>10</sup>:

- a. Location: rural vs. urban (N=90)
- b. System membership: a health system or a hospital that is a member of a health system vs. independent (N=107)
- c. Bed Size: small (less than 100 beds) vs. medium (between 100 and 399 beds) vs. large (400 or more beds) (N=76)

Because these hospital characteristics were not available for all 158 respondents, the samples used for these subgroup analyses are only a subset of the full set of respondents, as the sample sizes (Ns) listed above indicate. Moreover, the sample sizes differed across the three sets of analysis as explained next.

Out of the 158 respondents, 77 could be matched to a hospital AHA ID, confirming that the respondent was a hospital (instead of a system), but one AHA ID was not present in the 2020 Annual Survey database; therefore, hospital-level characteristics were available for only 76 respondents. Only these 76 respondents could be included in the analysis by bed size. Because we were able to match 31 additional respondents to their system ID but not to their hospital ID, we defined system membership as a respondent (which could be a hospital or a health system) that could be linked to a system ID. This resulted in a total sample size of 107 respondents for the analysis by system membership (76 from the matched hospital AHA IDs plus 31 from the matched system IDs). For the subgroup analysis by location, we were able to assign rural or urban designations to the 76 respondents identified as hospitals plus 14 additional respondents that could not be linked to their AHA IDs but could be linked to a health system ID. For these 14 respondents, rural or urban designations were determined as follows: (1) if a respondent was associated with a system ID whose member hospitals are all rural hospitals, then that respondent was classified as rural; (2) if a respondent was associated with a system ID whose member hospitals are all urban hospitals, then that respondent was classified as urban; (3) if neither (1) nor (2) held, then that respondent's rural or urban designation remained missing, and the respondent was not included in the rural versus urban analysis. This process resulted in a total of 90 (=76 + 14) respondents for the analysis by location.

## Subgroup Analysis by Hospital Characteristics, Final Survey, Questions 1 through 5

In this section, we provide a summary of the overall results of the three subgroup analysis (by respondents' location, system membership, and bed size) for Questions 1 through 5 of the final survey, followed by more detailed results for each set of analysis. These findings highlight differences in the self-reported 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 that the respondents encounter in these areas. For each graph presented in the detailed results, response categories are sorted from the most frequently to the least frequently selected.

<sup>10</sup> We were not able to conduct subgroup analysis by primary service types (children's hospital, psychiatric hospital, rehabilitation hospital) because of small subgroup sample sizes. For example, none of the 76 respondents matched to a hospital AHA ID were rehabilitation hospitals, only eight were psychiatric hospitals, and only four were children's hospitals. These service types are also not mutually exclusive designations in that a hospital can be both a children's and a psychiatric hospital, as is the case for example if its primary service designation was children's psychiatric hospital.

## Brief Summary of Findings

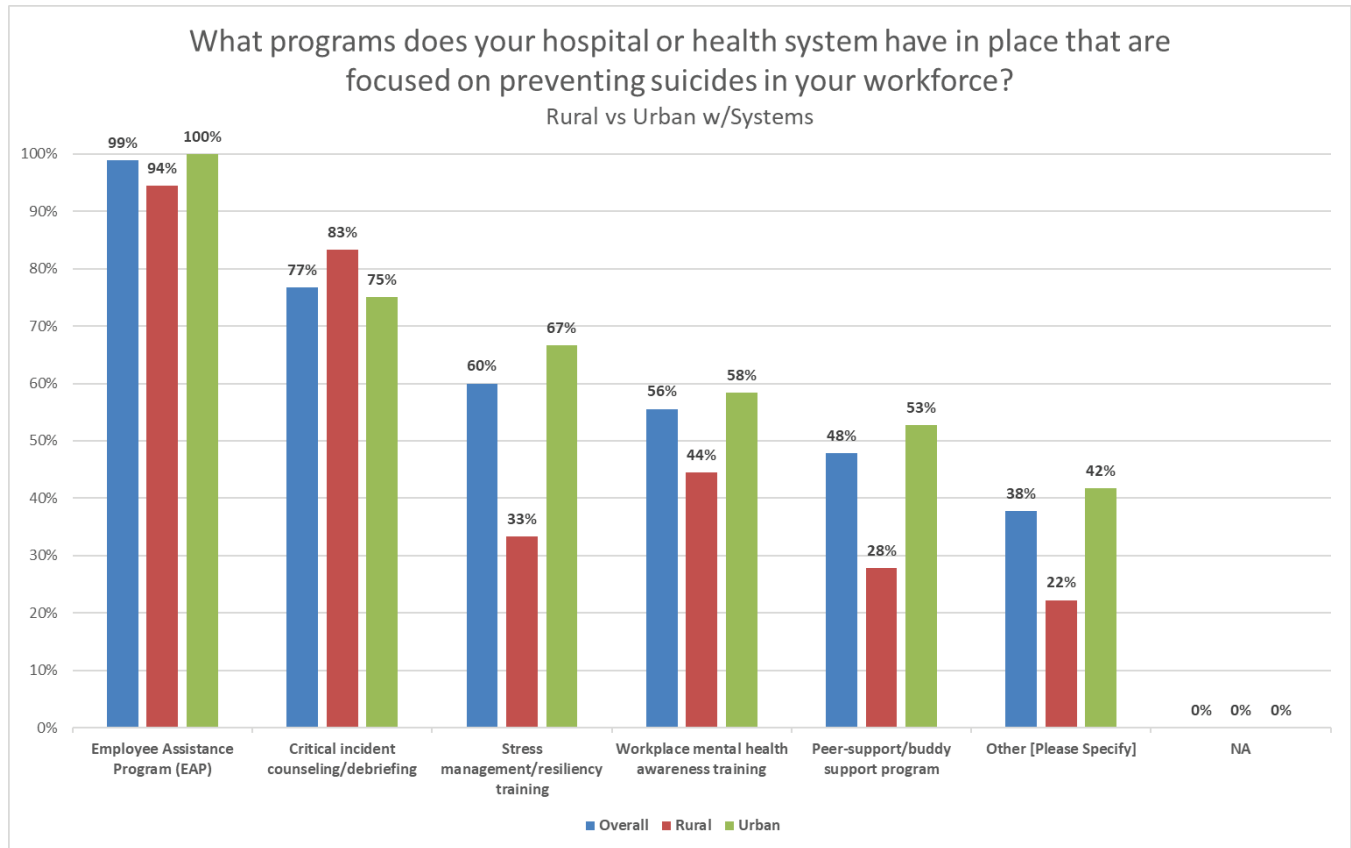
- Compared to their urban counterparts, rural respondents (whether a rural hospital, or a health system comprised exclusively of rural hospitals) were generally less likely to have programs and services in place for suicide prevention, and maintenance and growth of the resilience and purpose of their workforce (*Final Survey, Questions 1 and 4*). This suggests that the implementation infrastructure (staffing, resources, and programs) that exists in urban respondents' organizations may not be as available in rural respondents' organizations.
- Responses across the Final Survey questions analyzed did not differ much between independent hospital respondents and respondents who are either health systems or hospitals associated with health systems, with one exception: peer support groupings. Compared to independent hospitals, system hospitals or health systems reported higher rates of implementing profession-specific peer groups (*Final Survey, Question 2*). This suggests that systems or hospitals affiliated with systems might have more resources available to create profession-specific peer support groups, and perhaps greater number of staff to make these profession-specific groupings meaningful.
- Larger hospitals are implementing suicide prevention programs, profession-specific peer groups, and programs aimed at increasing feelings of psychological safety for health care workers at generally higher rates than either small or medium hospitals (*Final Survey, Questions 1, 2, and 5, respectively*). Like urban hospitals, these findings suggest that large hospitals may have more capacity and resources to provide programs and resources for their health care workers' mental well-being.

### **Infrastructure and resource challenges and barriers to having mental health programs in smaller, rural, and/or independent hospitals may include:**

- Shortage of mental and behavioral health experts that can care for healthcare staff, and lead, support, and advocate for the adoption of mental health programs
- Less demand for these programs because of the perceived stigma that is associated with seeking mental health services and the lack of anonymity particularly in more rural areas or smaller hospitals.
- Poor digital technology which limits access to telehealth mental health programs that may otherwise be available to larger, urban, or system hospital
- Lack of staff time to devote to adopting, implementing, maintaining, and participating in these programs
- Lack of screening tools to identify workers that need these services, and hence lacking justification or need for these programs
- Lack of awareness on the part of hospital leaders as well as their staff about the existence of evidence-based or recommended mental health services
- Lack of funding, space, and staff dedicated to mental health programs
- Programs that are developed for larger or urban hospitals, or hospitals that are parts of health systems in might not be easily adaptable to smaller, rural, and/or independent hospitals.

## A. Subgroup Analysis Findings by Location (Rural vs. Urban)

**Figure A-1. Rural versus Urban Hospitals or Health Systems: Responses to Final Survey, Question 1 (Total N: 90; Rural: 18; Urban: 72)**

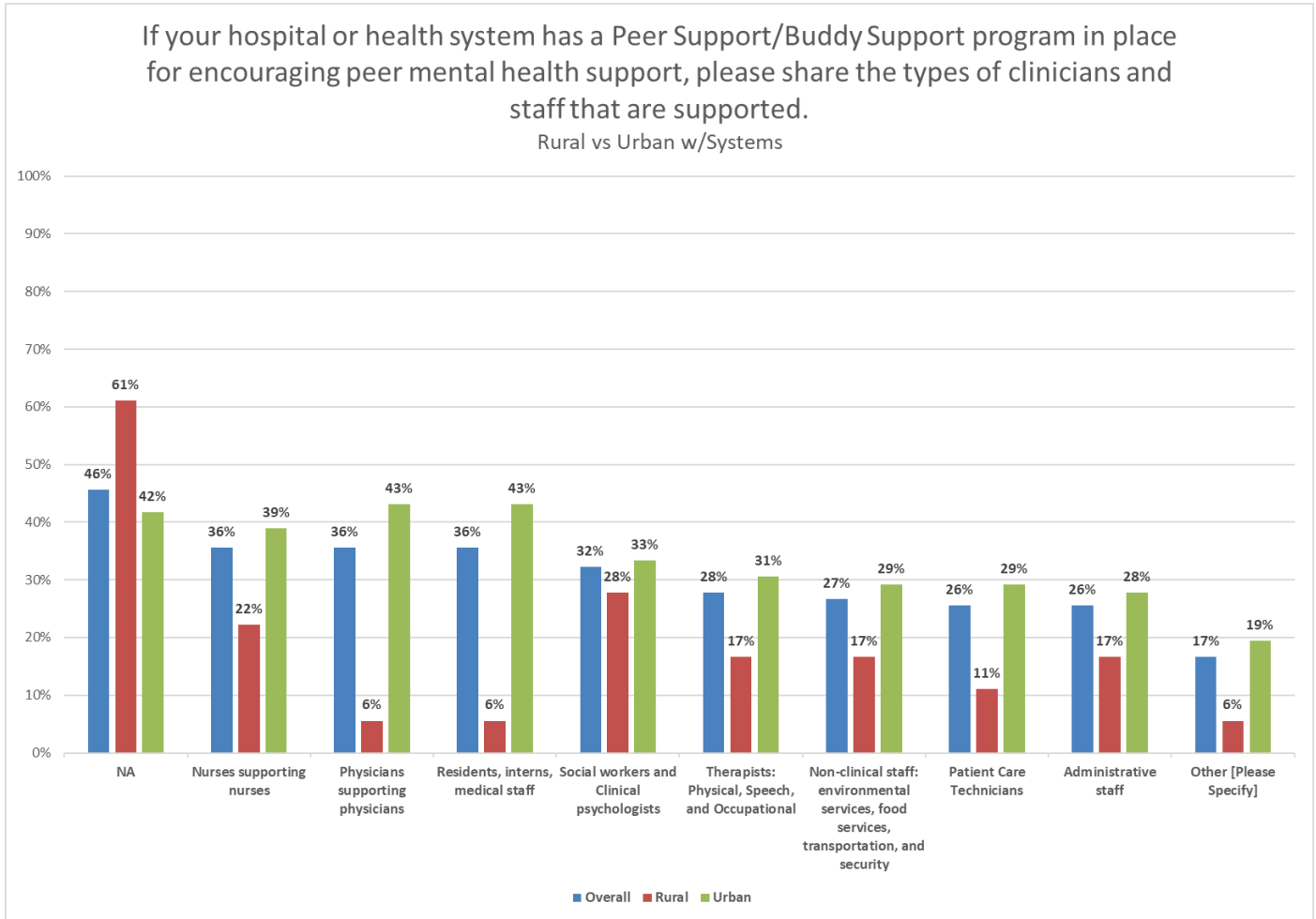


Among the 90 respondents included in this analysis, Employee Assistance Programs were in place for health care worker suicide prevention in all urban hospitals or health systems (100%) and in more than 9 out of every 10 rural hospitals or health systems (94%). Except for critical incident counseling/debriefing, which was available at a higher rate among rural respondents compared to their urban peers (83% vs. 75% respectively), all other suicide prevention programs listed as options (including “Other” programs) had substantially higher availability rates among urban hospitals or health systems than among their rural counterparts. Most notably:

- **Stress management/ resiliency training:** 67% of urban hospitals or health systems compared to 33% of their rural counterparts.
- **Workplace mental health awareness training:** 58% of urban hospitals or health systems compared to 44% rural health systems.
- **Peer-support/ buddy support programs:** 53% of urban health systems compared to 28% of rural.
- **“Other” programs:** 42% of urban health systems compared to 22% of rural health systems.

These differences between rural and urban respondents suggest that urban hospitals or health systems may have more resources available for implementing suicide prevention programs for their health care workers.

**Figure A-2. Rural versus Urban Hospitals or Health Systems: Responses to Final Survey, Question 2 (Total N: 90; Rural: 18; Urban: 72)**

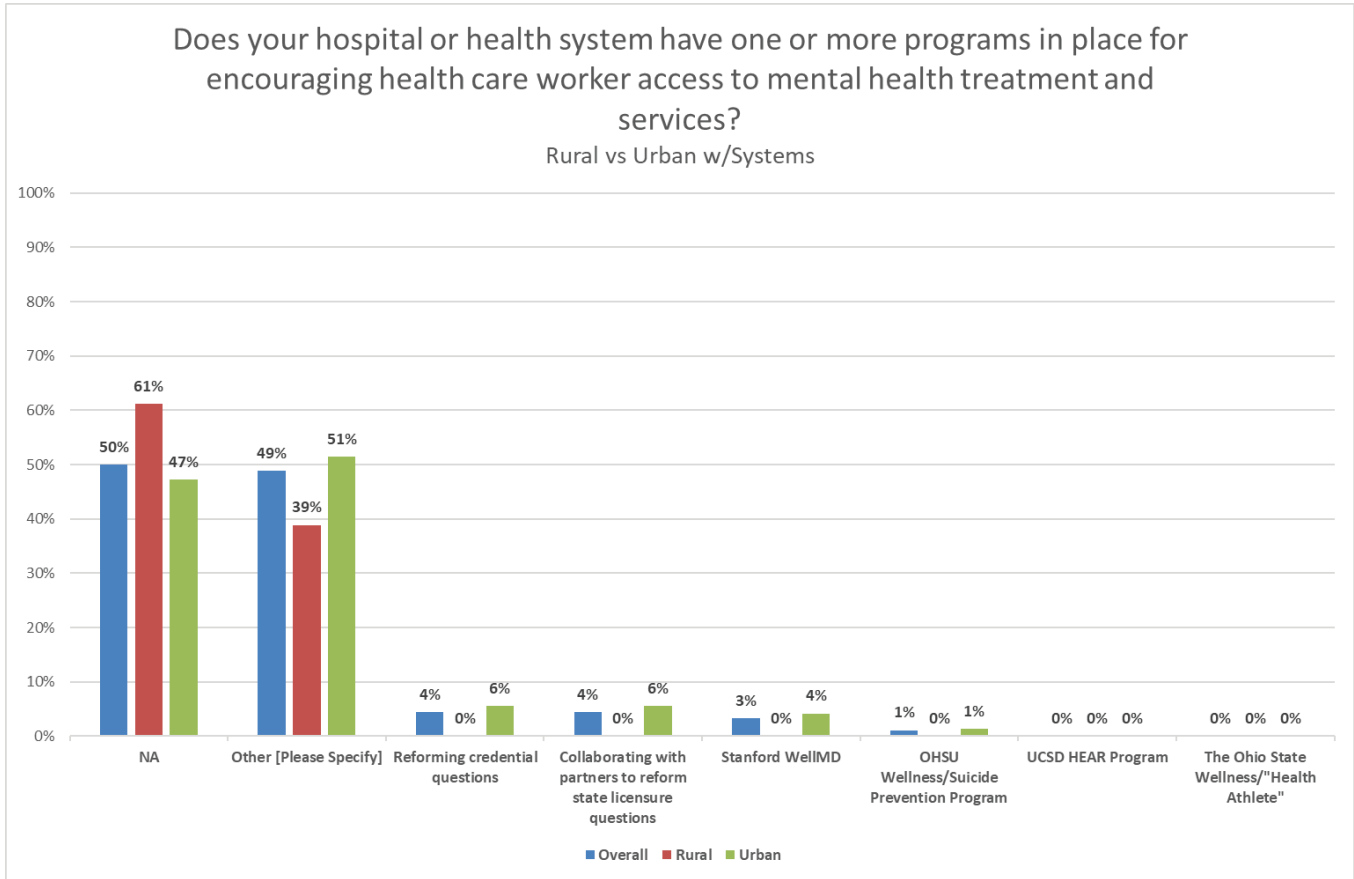


Urban hospitals or health systems had higher rates of peer support systems in place than rural hospitals or health systems across the various peer support groupings. The most substantial differences were among:

- **Nurses supporting nurses:** 39% of urban hospitals or health systems compared to 22% rural hospitals or health systems
- **Physicians supporting physicians:** 43% of urban hospitals or health systems compared to only 8% rural hospitals or health systems
- **Residents, interns, medical staff support supporting their peers:** 43% of urban hospitals or health systems compared to only 6% rural hospitals or health systems

It is also worth noting that 61% of rural hospitals or health systems selected “NA” for peer support groups, compared to only 42% of urban hospitals. This suggests that compared to urban hospitals, the infrastructure and resources for peer support groups might be less available in rural hospitals or health systems, and/or the number of staff needed to create meaningful profession-specific peer support groups may be insufficient in rural hospitals, which tend to be smaller and hence, have fewer staff than their urban counterparts.

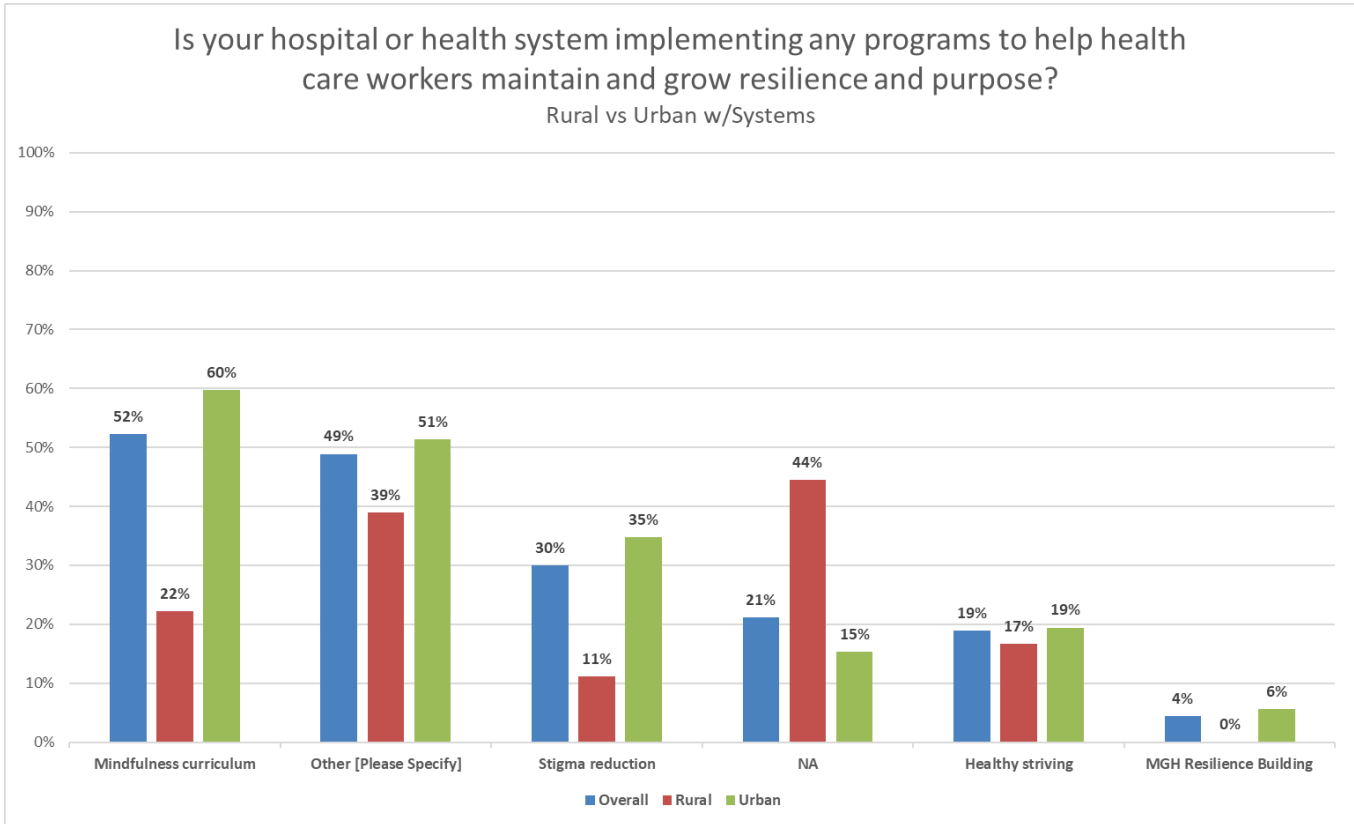
**Figure A-3. Rural versus Urban Hospitals or Health Systems: Responses to Final Survey, Question 3 (Total N: 90; Rural: 18; Urban: 72)**



Survey question 3 garnered mostly “NA and “Other” responses from both rural and urban hospitals and health systems. Of note, a larger percentage of rural hospitals or health systems reported “NA” (61%) compared to urban hospitals or health systems (47%). As in Question 1 above, this trend might be indicative of the lack of infrastructure or resources in rural facilities to implement these types of programs. Interestingly, as noted in the overall analysis of Question 3 in the Final Survey (see Key Findings section), a very small percentage of respondents (0% to 6%) reported having in place any of the specific programs listed (e.g., Stanford WellIMD, UCSD HEAR Program), but a large percentage of both rural (39%) and urban (51%) respondents selected the “Other” option, indicating that the while the more well-known types of program are not being adopted, both rural and urban respondents are implementing other types of programs, most notably EAPs, to encourage worker access to mental health treatment and services, although more so among urban hospitals or health systems (51%) than among their rural counterparts (39%).



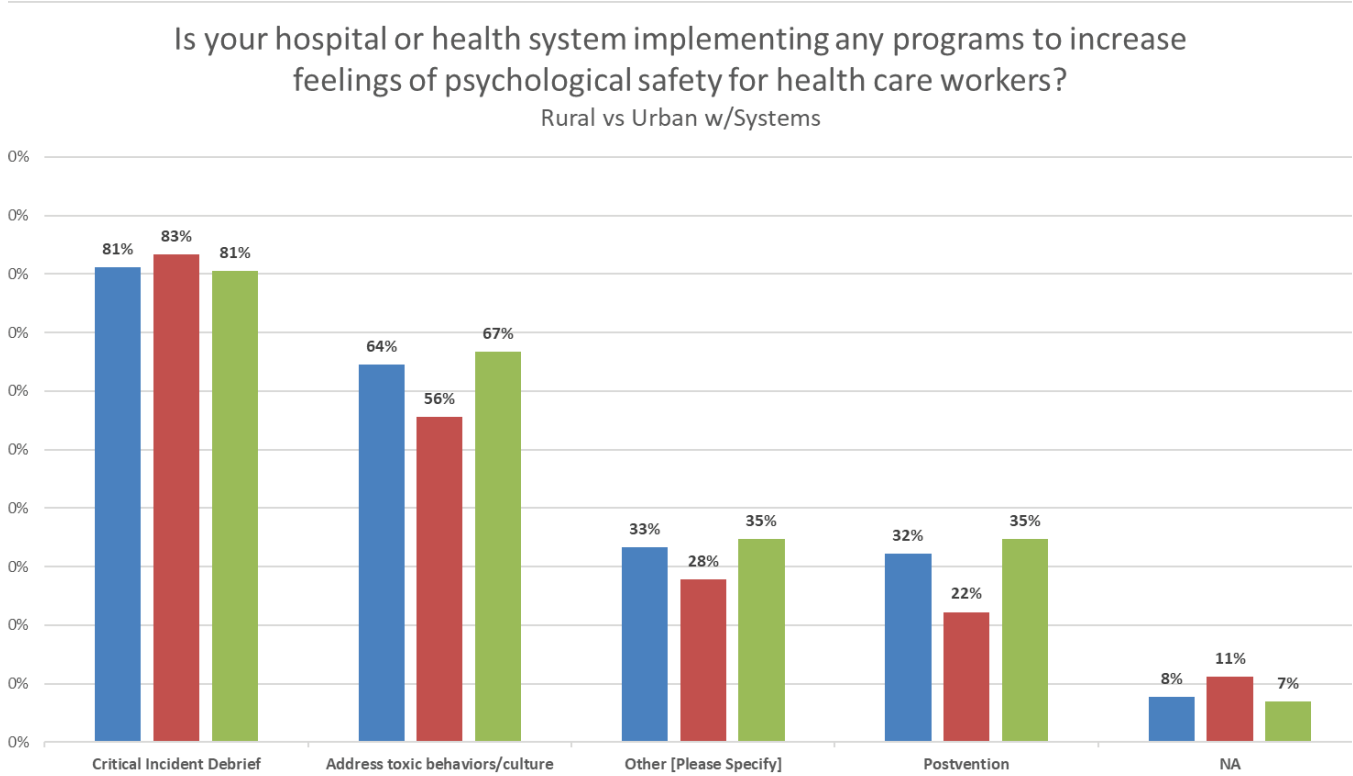
**Figure A-4. Rural versus Urban Hospitals or Health Systems: Responses to Final Survey, Question 4 (Total N: 90; Rural: 18; Urban: 72)**



Rural hospitals or health systems were more than twice as likely to select “NA” than to urban hospitals or health systems (44% vs. 21%). This suggests that rural hospitals or health systems are less likely than their urban counterparts to have the infrastructure/resources to implement the specific programs listed or “Other” programs. For the remainder of the response options, urban respondents reported implementing programs to help health care workers maintain and grow resilience and purpose at consistently higher rates than their rural counterparts. The most notable differences were:

- **Mindfulness curriculum:** 60% of urban hospitals or health systems compared to 22% of rural hospitals or health systems
- **Stigma reduction:** 35% of urban hospitals or health systems compared to 11% rural hospitals or health systems
- **“Other” programs:** 51% of urban hospitals or health systems compared to 39% of rural hospitals or health systems.

**Figure A-5. Rural versus Urban Hospitals or Health Systems: Responses to Final Survey, Question 5 (Total N: 90; Rural: 18; Urban: 72)**



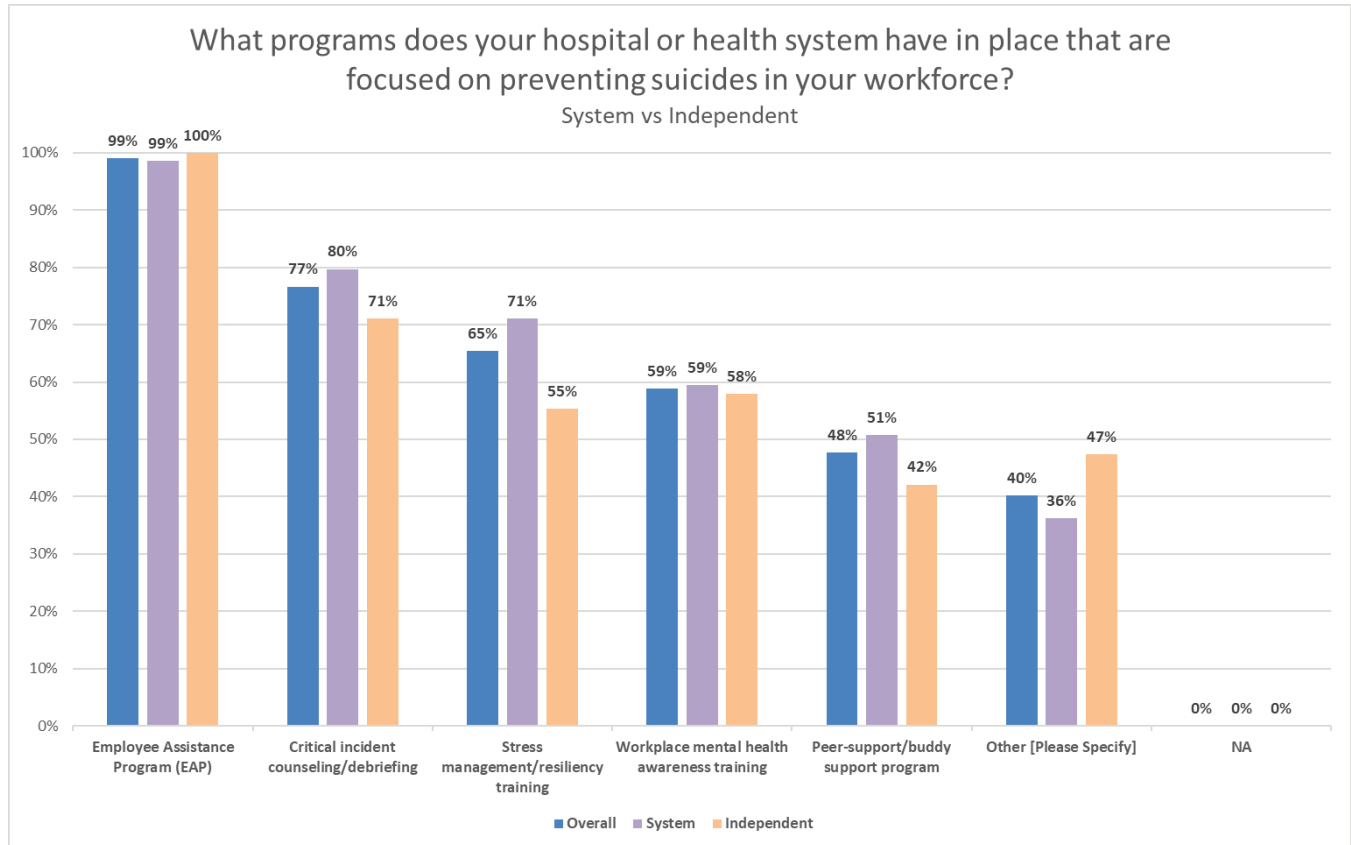
While **very similar percentages of rural and urban respondents (83% and 81%, respectively) reported implementing critical incident debrief** to increase healthcare workers’ feelings of psychological safety, **rural hospitals or systems were generally more likely to implement all the other programs than their urban counterparts**, again suggesting that the latter might have more resources to implement these programs than the former. Specifically:

- **Addressing toxic behaviors/ culture:** 67% urban hospitals or health systems compared to 56% of rural hospitals or health systems
- **Postvention programs:** 35% urban hospitals or health systems compared to 22% rural hospitals or health systems
- **“Other” programs:** 35% of urban hospitals or health systems compared to 11% rural hospitals or health systems

On the contrary, a slightly larger percentage of rural respondents selected the “NA” category than urban respondents (11% vs, 7%).

## B. Subgroup Analysis Findings by System Membership (Health Systems or Hospitals within Health Systems vs. Independent Hospitals)

**Figure B-1. Health Systems or Hospitals within Health Systems versus Independent Hospitals: Responses to Final Survey, Question 1 (Total N: 107; Hospitals in Health Systems or Health Systems: 69; Independent Hospitals: 38)**

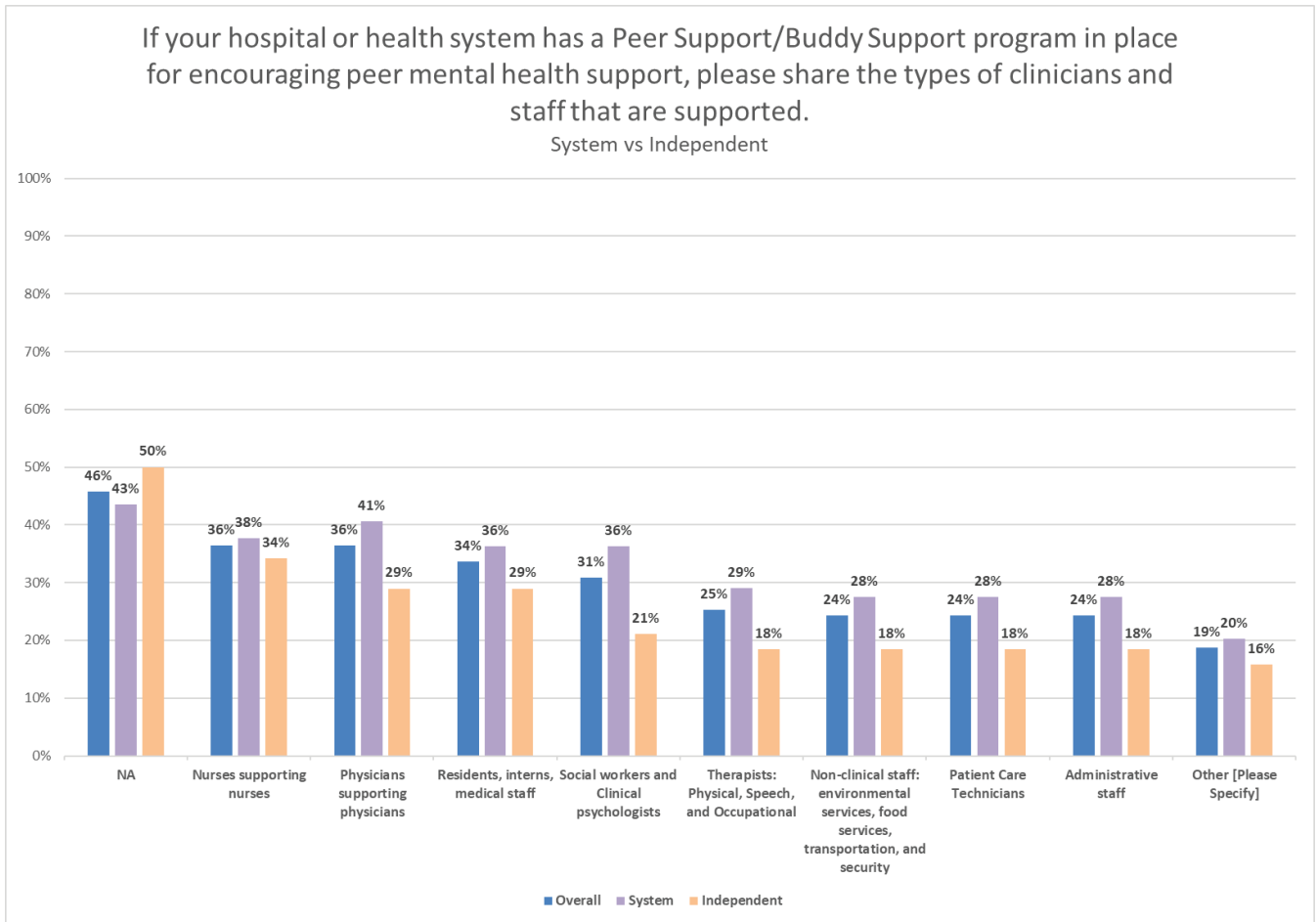


**Employee Assistance Programs focused on workforce suicide prevention are reportedly in place in practically all 107 responding hospitals included in this analysis:** (99% of hospitals in health systems or health systems, and 100% of independent hospitals). Health systems or hospitals in health systems had consistently higher rates of adoption for the following programs:

- **Critical Incident counseling/debriefing:** 80% of hospitals in health systems or health systems compared to 71% of independent hospitals
- **Stress management/resiliency training:** 71% of hospitals in health systems or health systems compared to 55% of independent hospitals.
- **Peer-support/ buddy support programs:** 51% of hospitals in health systems or health systems compared to 42% of independent hospitals.

However, **independent hospitals had higher rates of having “Other” programs in place for suicide prevention compared to health systems or hospitals in health systems (47% vs. 36%).** This suggests that while independent hospitals might not be implementing the more well-known suicide prevention programs as much as health systems or hospitals in health systems, they seem to be adopting other types of programs at higher rates than system-affiliated respondents.

**Figure B-2. Health Systems or Hospitals within Health Systems versus Independent Hospitals: Responses to Final Survey, Question 2 (Total N: 107; Hospitals in Health Systems or Health Systems: 69; Independent Hospitals: 38)**

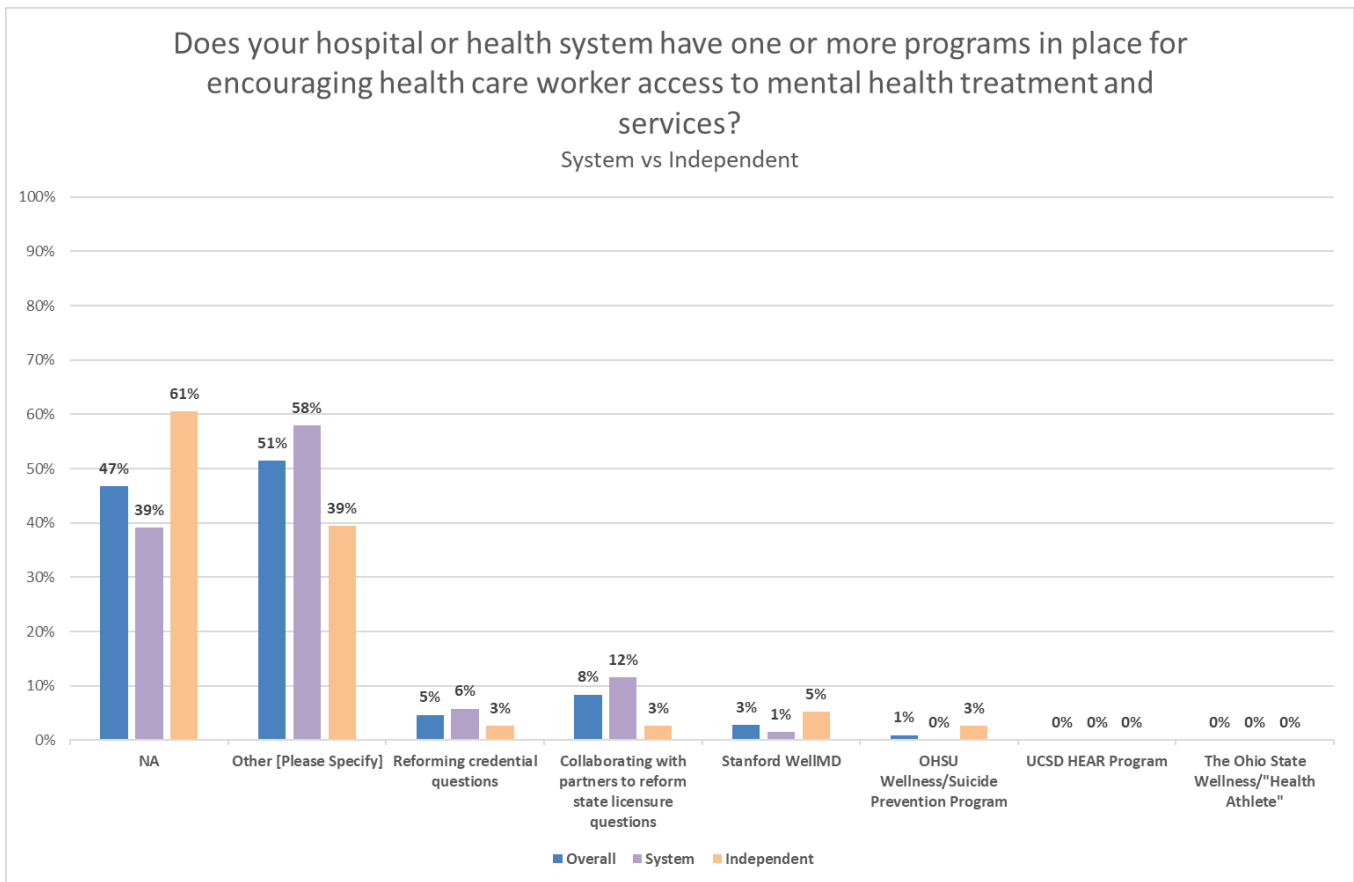


**Health systems or hospitals in health systems had consistently higher rates of peer support systems in place than independent hospitals across all the various peer support groupings,** although the rates were more similar for nurses supporting nurses, and “Other” peer support groups. The most notable differentials were:

- **Physicians supporting physicians:** 41% of health systems or hospitals in health systems compared to 29% of independent hospitals
- **Social workers and clinical psychologists:** 36% of health systems or hospitals in health systems compared to 21% of independent hospitals
- **Therapists (physical, speech, and occupational):** 29% of health systems or hospitals in health systems compared to 18% of independent hospitals
- **Non-clinical staff, Patient Care Technicians, and Administrative Staff:** For each of these three peer grouping options: 28% of health systems or hospitals in health systems compared to 18% of independent hospitals

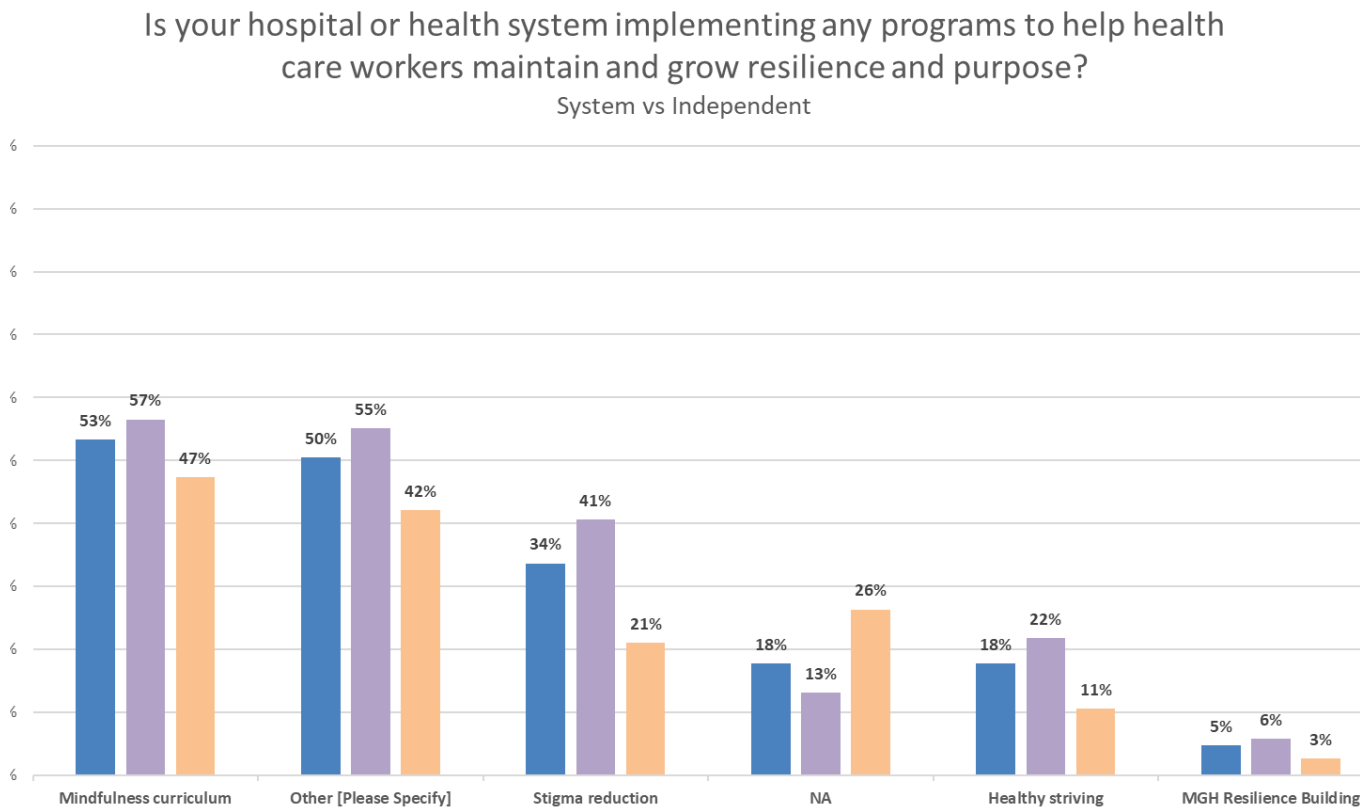
These findings suggest health systems or hospitals within health system have more resources and greater number of staff that make implementation of profession-specific peer support groups more feasible than their independent counterparts.

**Figure B-3. Health Systems or Hospitals within Health Systems versus Independent Hospitals: Responses to Final Survey, Question 3 (Total N: 107; Hospitals in Health Systems or Health Systems: 69; Independent Hospitals: 38)**



This question garnered mostly “NA and “Other” responses from both independent hospitals and hospitals in health systems or health systems. Of note, **a larger percentage of independent hospitals reported “NA” (61%) compared to health systems or hospitals within health systems (39%)**. This trend might be indicative of the lack of infrastructure or resources in independent facilities to implement these types of programs. As before, **a very small percentage of respondents (0% to 12%) reported having in place any of the specific programs listed** (e.g., Stanford WellIMD, UCSD HEAR Program), but **a large percentage of both independent hospitals (39%) and hospitals in health systems or health systems (58%) selected the “Other” option**, indicating that the while the more well-known types of program are not being adopted, both independent hospitals and system-affiliated respondents are implementing other types of programs, particularly EAPs (see overall analysis findings of Final Survey, Question 3 in the Key Findings section) to encourage worker access to mental health treatment and services, more so among the latter (58%) than the former (39%).

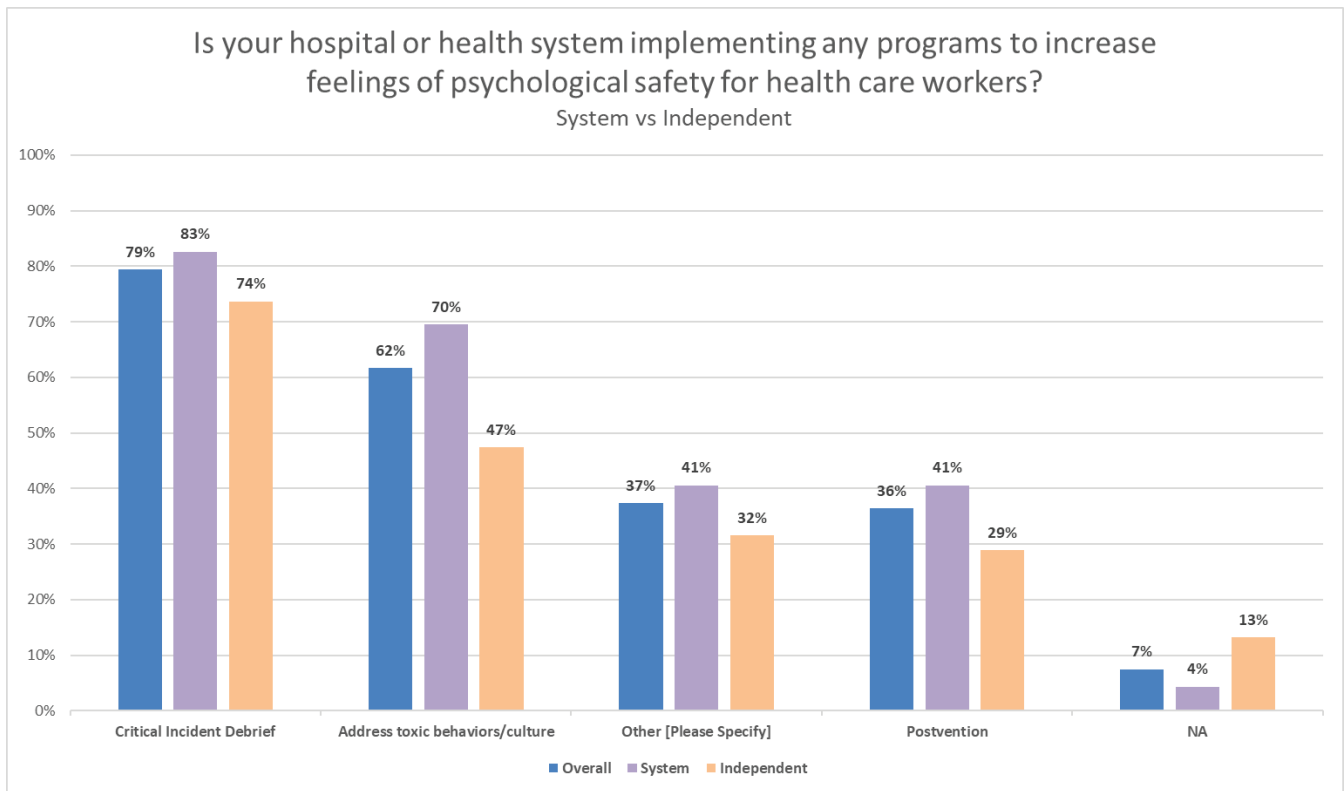
**Figure B-4. Health Systems or Hospitals within Health Systems versus Independent Hospitals: Responses to Final Survey, Question 4 (Total N: 107; Hospitals in Health Systems or Health Systems: 69; Independent Hospitals: 38)**



**Independent hospitals were twice as likely to select the “NA” option than health systems or hospitals in health systems (26% vs. 13%).** This suggests that independent hospitals are less likely than hospitals in health systems or health systems to have the infrastructure and resources to implement the specific programs listed (including “Other” programs). For the rest of the response options, **health systems or hospitals in health systems reported implementing programs to help health care workers maintain and grow resilience and purpose at consistently higher rates than independent hospitals.** The most notable of these differences were:

- **Mindfulness curriculum:** 57% of health systems or hospitals in health systems compared to 47% of independent hospitals
- **Stigma reduction:** 41% of health systems or hospitals in health systems compared to 21% of independent hospitals
- **Healthy striving:** 22% of health systems or hospitals in health systems compared to 11% of independent hospitals
- **“Other” programs:** 55% of health systems or hospitals in health systems compared to 42% of independent hospitals

**Figure B-5. Health Systems or Hospitals within Health Systems versus Independent Hospitals: Responses to Final Survey, Question 5 (Total N: 107; Hospitals in Health Systems or Health Systems: 69; Independent Hospitals: 38)**



**Health systems or hospitals within health systems were consistently more likely to implement programs aimed at increasing feelings of psychological safety for health care workers than independent hospitals.** Specifically:

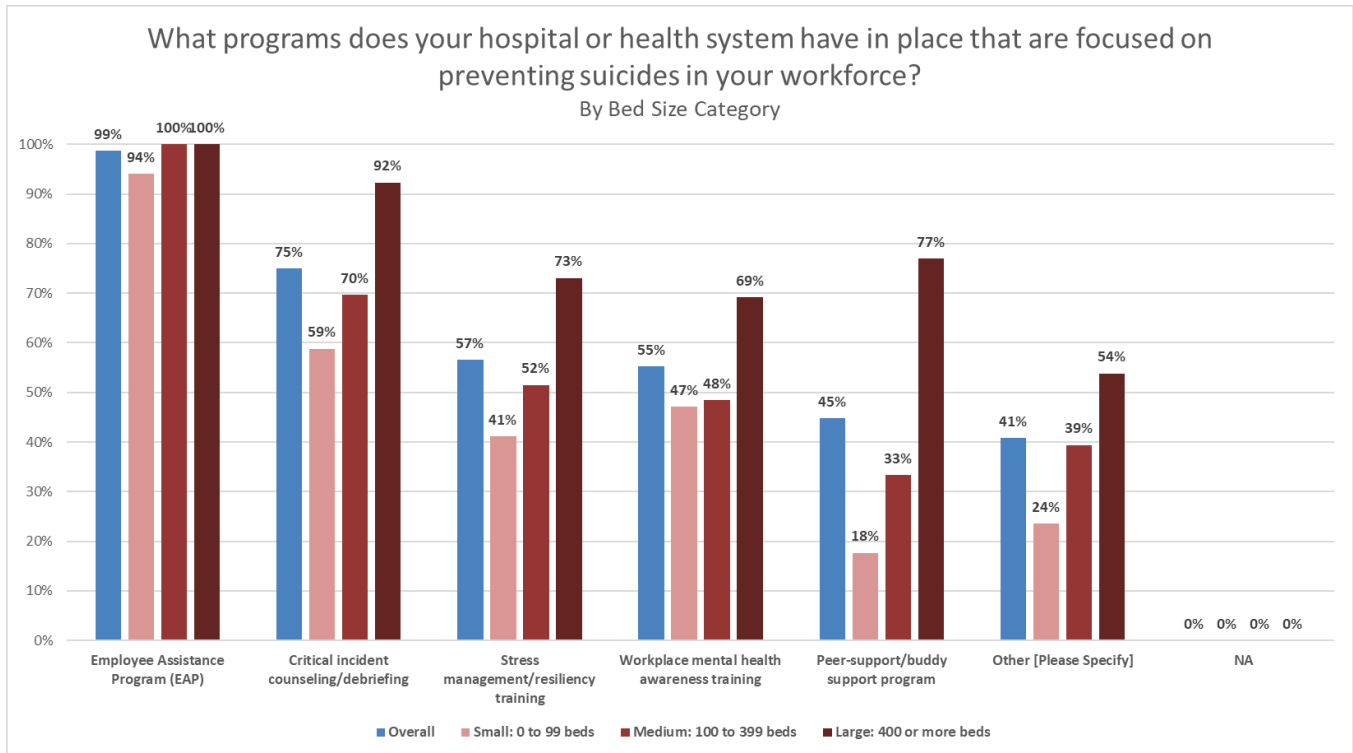
- **Critical Incident Debrief:** 83% of health systems or hospitals within health systems compared to 74% of independent hospitals
- **Addressing toxic behaviors/ culture:** 70% of health systems or hospitals in health systems and 47% of independent hospitals
- **“Other” programs:** 41% of health systems or hospitals in health systems compared to 32% of independent hospitals
- **Postvention programs:** 41% of health systems or hospitals in health systems compared to 29% of independent hospitals

However, a larger percentage of independent hospitals selected the “NA” category than hospitals in health systems or health systems (13% vs. 4%, respectively).

The above findings suggest that health systems or hospitals in health systems implement programs for increasing feelings of psychological safety among health care workers at higher rates than independent hospitals, which can be due to more resources available in hospitals in health systems or health systems.

## C. Subgroup Analysis Findings by Hospital Bed Size (Small vs. Medium vs. Large)

Figure C-1. Hospital Bed Size Categories: Responses to Final Survey, Question 1 (Total N: 76; Small: 17; Medium: 33; Large: 26)

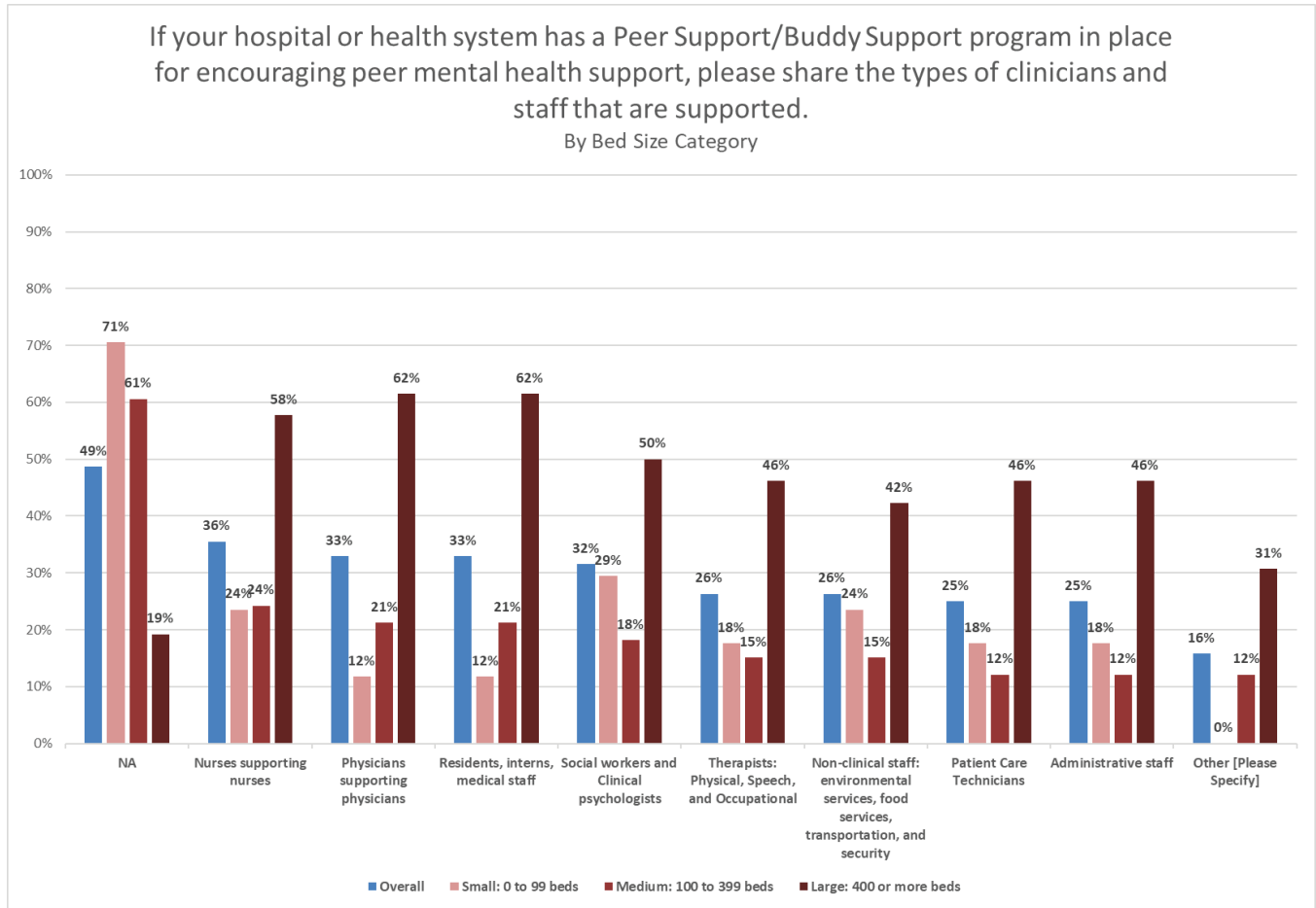


Among the 76 respondents included in this analysis, Employee Assistance Programs (EAPs) were utilized similarly across hospital sizes (Small: 94%, Medium: 100%, and Large: 100%), but **all the other the suicide prevention programs listed were consistently available to a greater extent as the hospital size increased.** This suggests that the larger the hospital, the more resources they may have available to implement these programs (including programs that fall under the “Other” category). Specifically, as shown in Figure C-1, except for the similar rates of availability of workplace mental health awareness training between small- and medium-sized hospitals, there were wide gaps across bed size categories in the following programs:

- **Critical Incident counseling/debriefing:** Small: 59%, Medium: 70%, and Large: 92%
- **Stress management/resiliency training:** Small: 41%, Medium: 52%, and Large: 73%
- **Workplace mental health awareness training:** Small: 47%, Medium: 48%, and Large: 69%
- **Peer-support/buddy support program:** Small: 18%, Medium: 33%, and Large: 77%
- **“Other” programs:** Small: 24%, Medium: 39%, and Large: 54%



**Figure C-2. Hospital Bed Size Categories: Responses to Final Survey, Question 2 (Total N: 76; Small: 17; Medium: 33; Large: 26)**

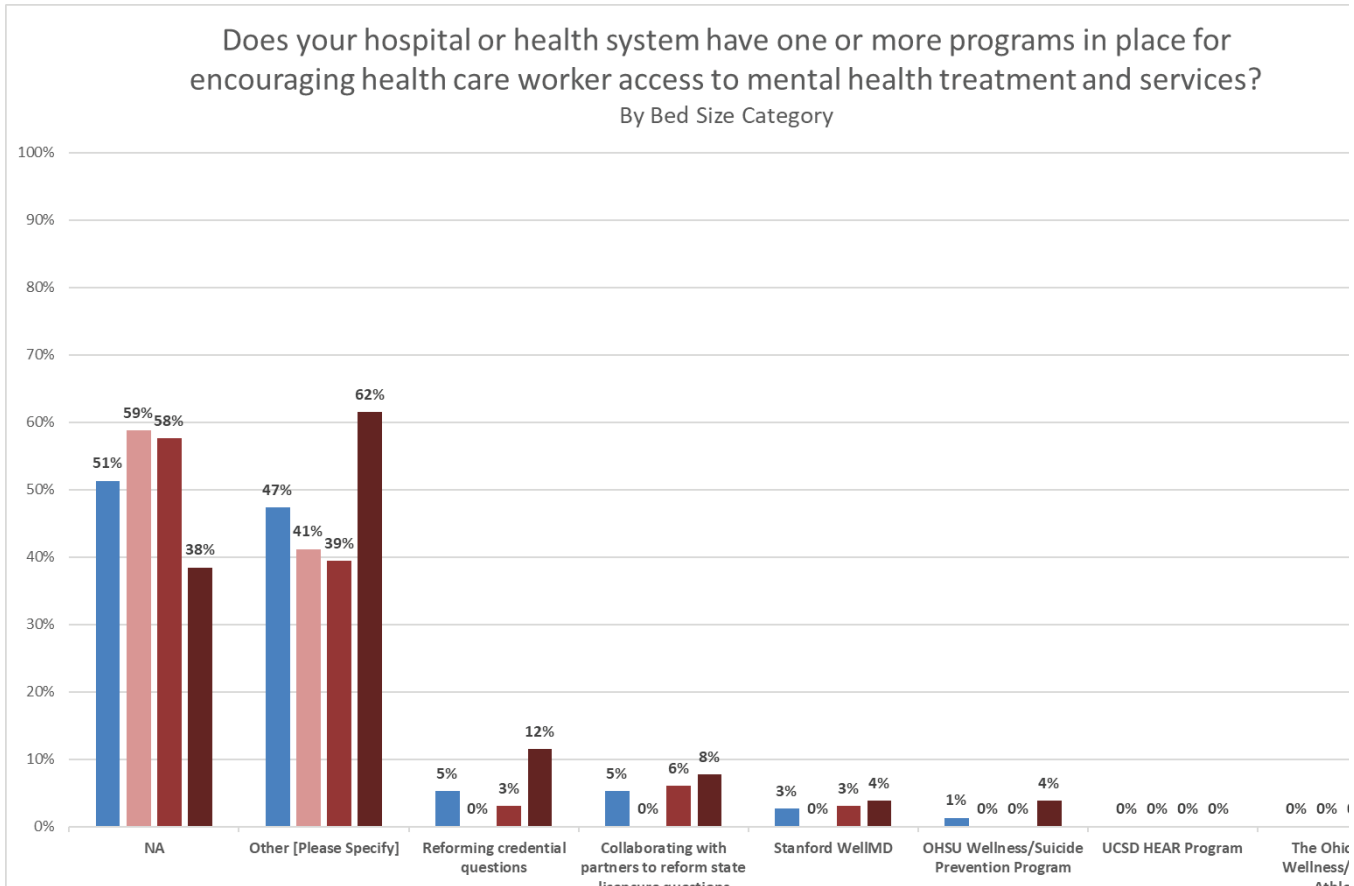


Like suicide prevention programs (Final Survey, Question 1 above), **peer support/buddy support programs were consistently available to a greater extent in larger than in small- or medium-sized hospitals.** Specifically:

- Large hospitals had the highest rates of having the following peer-support groupings in place, often by wide margins:
  - **Nurses supporting Nurses:** Large: 58%, Medium: 24%, Small: 24%
  - **Physicians supporting Physicians:** Large: 62%, Medium: 21%, Small: 12%
  - **Residents, interns, medical staff:** Large: 62%, Medium: 21%, Small: 12%
  - **Social workers and Clinical psychologists:** Large: 50%, Medium: 18%, Small: 29%
  - **Therapists: Physical, Speech, and Occupational:** Large: 46%, Medium: 15%, Small: 18%
  - **Non-clinical staff: environmental services, food services, transportation, and security:** Large: 42%, Medium: 15%, Small: 24%
    - **Patient Care Technicians:** Large: 46%, Medium: 12%, Small: 18%
    - **Administrative staff:** Large: 46%, Medium: 12%, Small: 18%
  - **Other:** Large: 31%, Medium: 12%, Small: 0%
- Medium hospitals reported having the following peer-support groupings to a greater extent than small hospitals:

- **Nurses supporting nurses:** Medium: 24.2%, Small: 23.5%
  - **Physicians supporting physicians,** Medium: 21%, Small: 12%
  - **Residents, interns, medical staff,** Medium: 21%, Small: 12%
  - **Other,** Medium: 12%, Small: 0%
- On the other hand, following peer-support groupings were more prevalent among small hospitals compared to medium hospitals:
    - **Social workers and Clinical psychologists,** Small: 29%, Medium: 18%
    - **Therapists: Physical, Speech, and Occupational,** Small: 18%, Medium: 15%
    - **Non-clinical staff: environmental services, food services, transportation, and security,** Small: 24%, Medium: 15%
    - **Patient Care Technicians,** Small: 18%, Medium: 12%
    - **Administrative staff,** Small: 18%, Medium: 12%
  - Small hospitals (71%) selected the most NAs of the three groups, followed by medium hospitals (61%), then by large hospitals (19%), which may be due smaller hospitals lacking the infrastructure or resources to create or maintain these programs.

**Figure C-3. Hospital Bed Size Categories: Responses to Final Survey, Question 3 (Total N: 76; Small: 17; Medium: 33; Large: 26)**



Consistent with the overall analysis of responses by all 158 respondents to Question 3 in the Final Survey (see Key Findings section), the most popular options chosen by the 76 respondents included in this analysis are the “NA” and “Other” options, with the remaining specified programs selected at much lower rates (0% to 12%).

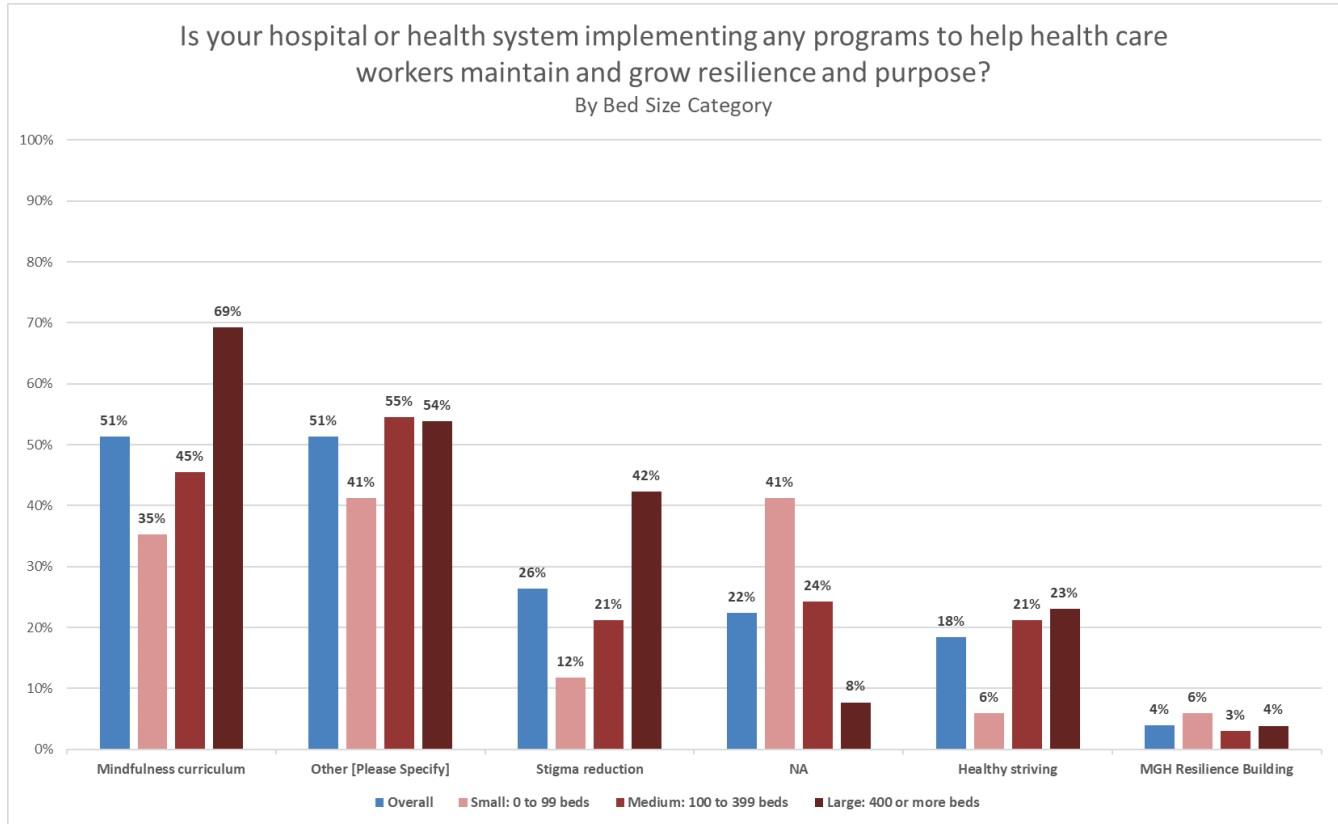
**As bed size increased (from small to medium to large), the reported prevalence of programs that encourage health care workers to access mental health treatment and services generally increased.**

Small hospitals, however, tended to pick “Other” programs (41%) at a slightly higher rate than medium hospitals (39%). Moreover, both small- and medium-sized hospitals (59% and 58%, respectively) selected the “NA” option to a much larger extent than large hospitals (38%). Both trends suggest that larger hospitals may have more resources to implement these types of programs compared to their small- and medium-sized counterparts. The biggest disparities across bed size categories were:

- **“Other” programs:** Small: 41%, Medium: 39%, Large: 62%
- **Reforming credential questions:** Small: 0%, Medium: 3%, Large: 12%

Collaborating with partners to reform state licensure questions (Small: 0%, Medium: 6%, Large: 8%), Stanford WellIMD (Small: 0%, Medium: 3%, Large: 4%), and OHSU Wellness/Suicide Prevention Program (Small: 0%, Medium: 0%, Large: 4%) also differed across bed size categories but to a lesser extent. Note that none of the 76 respondents included in this subgroup analysis, regardless of size, selected either the UCSD HEAR Program or the Ohio State Wellness/“Health. Athlete” Program.

**Figure C-4. Hospital Bed Size Categories: Responses to Final Survey, Question 4 (Total N: 76; Small: 17; Medium: 33; Large: 26)**

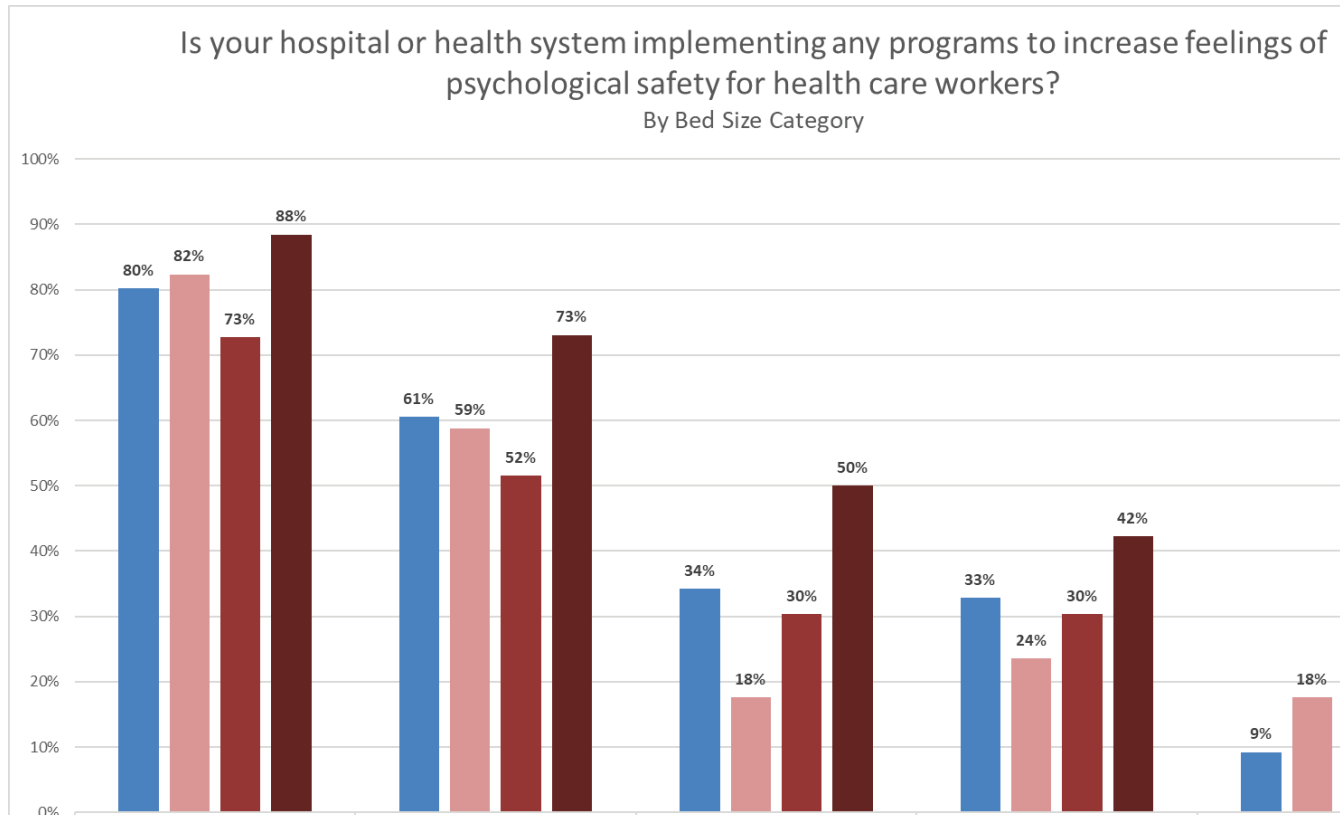


Except for MGH Resilience Building and the “NA” option, the reported prevalence of programs aimed at helping workers maintain and grow resilience and purpose were generally higher as the bed size increased. This trend and the fact that larger hospitals tended to select the “NA” option more than smaller hospitals did, **suggest that larger hospitals may have more resources to provide these types of programs compared to their small- and medium-sized counterparts.** Specifically, the biggest disparities across bed size categories were in:

- **Mindfulness curriculum:** Small: 35%, Medium: 45%, Large: 69%
- **Stigma reduction:** Small: 12%, Medium: 21%, Large: 42%
- **Health striving:** Medium and large hospitals had similar rates (21% and 23%, respectively) which were substantially higher than that of small hospitals (6%)
- **“Other” response:** Medium and large hospitals had similar rates (55% and 54%, respectively) which were substantially higher than that of small hospitals (41%)

Among the 76 respondents, small hospitals were more likely (6%) to report having the MGH Resilience Building program than either large (4%) or medium (3%) hospitals.

**Figure C-5. Hospital Bed Size Categories: Responses to Final Survey, Question 5 (Total N: 76; Small: 17; Medium: 33; Large: 26)**



Availability rates for the four types of programs listed for increasing feelings of psychological safety were consistently and substantially higher for large hospitals compared to small- and medium-sized hospitals. Moreover, the larger the hospital, the less likely they were to select the “NA” option. **These two findings indicate that large hospitals may have more resources to implement these types of programs than both small and medium hospitals.**

The trend for small- and medium-sized hospitals, however, was inconsistent:

- On the one hand, medium hospitals reported higher rates of availability of **Postvention** (30% vs. 24%) and **“Other” programs** (30% vs. 18%) than small hospitals
- On the other hand, small hospitals reported having greater availability of **Critical Incident Debrief** (82% vs. 73%) and **programs that address toxic behavior/culture** (59% vs. 52%) than medium hospitals.
- This suggests that as far as programs that address workers’ psychological safety, there is no clear advantage for medium hospitals over small hospitals.