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Heart of Safety Coalition

Insights Huddle transcript

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Addressing drivers of healthcare worker suicide

Presenters: Rebecca B. Chickey, MPH, Senior Director, Field Engagement, Behavioral Health Services, and Jordan Steiger, MPH, AM, LSW, Senior Program Manager, Clinical Affairs and Workforce, from the American Hospital Association (AHA)
Moderator: Liz Boehm, Executive Strategist, Heart of Safety Coalition

Insights Huddles are a forum for leaders, learners, and advocates to share their bold voices and valuable insights. A mix between a webinar and a conversation, everyone from hospital executives to frontline clinicians are invited to set titles aside and put safety first. We share recordings of the didactic portions of Insight Huddles, and we summarize the discussions in written format. We hope this strikes the right balance between our aim to spread great ideas as far as possible and our desire to create psychologically safe forums where participants can ask questions and share stories with vulnerability. We believe that together, we can spark big ideas and drive meaningful change for the safety and wellbeing of team members across our health systems.

Liz Boehm: Welcome, folks. Thank you so much for joining. For those who don't know me, my name is Liz Boehm. I am the executive strategist with the Coalition and leader of most of these Insights Huddles. Today, we're focusing on addressing drivers of healthcare worker suicide. For those of you who have been with us since the beginning, our very first Insights Huddle was focused on this topic.

It's something that is at the far end of the continuum of wellbeing and mental health and distress but certainly an area where there's a critical focus given that the percentage of healthcare team members who die by suicide is still well above the average for folks in their gender, whether that's nursing or physicians or other groups for whom we don't have good data.

Jordan Steiger and Becky Chickey from the AHA are going to walk us through some really powerful tools that they've created and that are available in the public domain, so available for absolutely any organization that wants to be focused on this area. What I loved when I saw Jordan and Becky originally, or when I saw Becky originally present this, but it's Jordan and Becky's work together, I loved that it includes some really practical experience from a cohort of folks who worked with the tools, helped to create the tools, and looked at what their impact will be.

Without any further ado, I'm going to hand it over to Jordan and Becky. Thank you so much for being here with us today and for focusing in on this critical topic.

Jordan Steiger: We're happy to be here.

Rebecca B. Chickey: Absolutely. First of all, Liz, thank you for inviting us to be here today. When we first started on this journey, it was at the cusp of COVID but before that, there were healthcare worker suicides, and there wasn't a lot of energy around addressing the challenge across the board. We'll get into a little bit of that as we describe our research, but it is a sliver, I think, of a silver lining of the impact of COVID to see the continued passion, focus, attention, funding to look into, how do we better support the mental wellbeing of our workforce?

That is critical, whether you are looking at it as a piece of your culture of safety initiative. It also links over to patient safety initiatives, but I just want to thank each and every one of you for being on this call today because this is, as Liz said, a broad part of the spectrum of really taking care of our workforce. Jordan, if you'll advance the next slide. I'm Rebecca Chickey. I'm the Senior Director of Behavioral Health at the American Hospital Association. The easiest way to describe what I do is that Jordan and I combined are the member engagement for individuals across the country of all of our behavioral health leaders.

That ranges from CEOs of freestanding psychiatric hospitals to critical access hospitals in rural areas to small geriatric units attached to a critical access hospital. We engage our members, and I've been at AHA for longer than I'm going to admit, but let's just say it's been over 20 years. Luckily, now I am joined by Jordan Steiger. I always say hire people that are smarter than you are, and in this case, it is certainly true. Jordan, please introduce yourself as well.

Jordan: I think we're equally smart, Rebecca, but thank you. Hi, everyone. I'm Jordan Steiger. I'm a Senior Program Manager for Clinical Affairs and Workforce at AHA. I'll just say ditto to everything Rebecca said. I'm really passionate about behavioral health. I'm a social worker by training. This topic is something that I've really come to, like I said, just be really passionate about over the last few years. So, I'm excited to share our work.

Rebecca: Today, what we hope you go away with is really a better understanding of the current research that is out there. After looking at all of the research and reaching out to our members and learning what they were doing, what we identified as the three key drivers, note key, so these are not the only drivers of suicide in the healthcare workforce but the primary ones, as well as 12 evidenced-informed interventions that can impact and reduce the risks of suicide in the healthcare workforce. Let me go there to evidence-informed, and we'll probably reinforce this throughout the presentation.

One of the things that you will learn is that there really wasn't a great deal of information out there that was evidence-based research. When we first started on this journey, we thought, this is going to be great. We'll be able to slice it and dice it and see what works at rural hospitals versus academic medical centers, what works at an independent hospital versus a multistate healthcare system. We'll, of course, be able to drill down and share with the field what works in terms of administrative staff versus medical records versus clinicians.

Surprise, there's not a lot of evidence-based research out there, so we turned to use the term evidenced-informed, meaning people are making an impact with this. Again, we'll reinforce that as we go through, but I wanted to clarify that up front. There's lots of opportunity for evidence-based research to continue to be done and identified. I know that all of you know this. This is why you're on the call. During the pandemic, the impact on our healthcare workforce was significant from diminishing mental wellbeing, increased suicide rates, increased burnout. Distinction, burnout is not a psychiatric diagnosis, as I hope you guys all well know, but sometimes people use those terms interchangeably, and I just want to stress that in our research, that is not the case.

You've seen multiple stories and studies about the psychological distress that COVID had in terms of the impact. What I think is new or enhanced, I guess not new completely, but enhanced, was the role that you saw hospitals and health systems stepping up to really say, what is my role in better supporting the mental wellbeing of the workforce, and through those efforts, hopefully reducing the risks of suicide?

The CDC reached out to us, or we actually reached out to them, and in applying for a grant, they said, "What is out there?" As I said earlier, there's not a lot. What we did find, and this is for all across the board, healthcare workers are at an elevated risk for suicide when they're compared to other professions, particularly for physician and nurses, and that's the category where the most evidence-based research is out there. Particularly, they drilled down and looked at differences in gender, and female-identifying nurses and physicians are even at a higher risk than their male counterparts. In addition to that, we looked at, what are the other general population risk factors? As we all know, certain age groups are at a higher risk. If you have certain physical disabilities, you may be at a higher risk. When we looked beyond nurses and physicians, the evidence-based research that was most prevalent after that was for veterinarians, which we found particularly confusing, but they are at a higher risk. I had thought it was going to be psychiatrists, or you've all heard probably about dentists having a higher suicide rate. When we really dug into the detail, and we did this. We did a lot of this research thanks to IHI.

It was wonderful to work with them to do this background work, but it was also very surprising. Eventually, as part of this, we also began to look at, okay, at least for physicians and nurses, are there any programs out there that are really showing promise? I will give a nod to the American Foundation for Suicide Prevention's Interactive Screening Program. That has been fairly effective at identifying those physicians, it's targeted at physicians, that are at a higher risk, and then matching them with resources. We can go more into the details of that, but I'd encourage you to take a look at the Interactive Screening Program.

Peer-to-peer support. There was some background there. Bystander training, as well as having in-house, a mental health support team. Now let me just say one stat there. When you look at the responses to AHA's annual survey data, only a third or so of America's hospitals, and these are members and non, have inpatient psychiatric services. That means two-thirds do not. Only two-thirds provide at least one psychiatric or substance use disorder services. That means a third of our hospitals and health systems in the country, more than likely, do not have any clinical providers with expertise in behavioral health care delivery on site.

That means for a third of them, it is significantly difficult to actually have dedicated in-house mental health support teams. Then there's the whole issue of workforce shortages as a whole, and particularly for behavioral health. We know that that particular solution is very challenging for many of our members. As I mentioned earlier, the CDC, once we applied for a grant, we were lucky enough to initially receive a one-year grant for roughly $400,000. They wanted us to identify and assess the evidence-based interventions. This work ran from October 1st in 2021 through the end of September in 2022.

We were successful in reapplying for a second year where we had $500,000 granted in addition to the $400,000 from year one. In year one, we basically said, all right, let's understand what the landscape is, what is already out there and known. Then in year two, which we'll come back to in a minute, we said, now that we know what is being tried out there, what is evidence-based and evidence-informed, let's see how we can distribute that information optimally and see if we can scale it across the country.
This is where I turn it over to Jordan because she led this initiative. I want to allow you to hear straight from the individual who really worked with our members closely as we rolled out our questions and our solutions.

Jordan: Thanks, Rebecca. We're going to focus on the year two outcomes, I think, for the rest of the presentation, just because that's really where we got into the meat of this work. Before we do that, I do want to highlight the final deliverable that we had from the first year of this project and everything that we're going to talk about for the rest of the time is really based on this tool that we developed.

This is our 16-page action-focused guide. We called it Suicide Prevention, Evidence-Informed Interventions for the Healthcare Workforce. It highlights the top three drivers of suicide that we identified

and then identifies metrics and just different solutions that you can take to actually address some of those drivers. As we're thinking about how we created this guide, Rebecca started to talk a little bit about some of this literature review, working very closely with IHI and the American Foundation for Suicide Prevention. They knew a lot more about this particular issue than we did at the beginning of all of this. We really turned to the experts that we knew we could partner with just to understand the issue a little bit more and see what they were seeing in the field. As Rebecca mentioned, there just wasn't, at that time, a ton of evidence-based academic research that was out there, so we were really trying to figure out how can we make this useful, but also make sure we're not just pulling together people's experiences? I mean, that's important, but we wanted to make sure that it was really grounded in evidence because anything we were asking our member hospitals to implement, we wanted to make sure was as close to the right thing as we could possibly give them.

After we went through all the literature, did that first piece of it, we turned to our member hospitals and health systems, so people exactly like you on the call who lead organizations, who work in wellbeing and work in patient care, just trying to understand what people are already doing in this space, what was working well for them, what wasn't working for them, what they were actually doing. We found a huge discrepancy across members just in the types of different programs that they had. We also found that people didn't always necessarily realize that they were doing suicide prevention work or doing wellbeing work.

We sent out a few surveys and did focus groups, interviews with different members. We'd say, "What are you doing around suicide prevention?" They'd say, "Oh, well, we don't have a suicide prevention program, but we've got a great EAP. We've got peer support programs." I think just reframing through all of this, too, that suicide prevention is a spectrum of different services that a lot of people are maybe already doing and didn't realize that they were doing. That was really good insight for us to have as we were getting further into this.

We took all of that data that we identified through surveys and the interviews and everything and used those to develop the drivers and the interventions, really looking at what was mentioned a lot, what we could find and align with the literature, things like that. We also made sure to vet all of the content in our guide with a large panel of subject-matter experts from different types of hospitals and health systems across the country. We wanted to make sure that we weren't putting out a guide that was maybe great evidence or great ideas but maybe wasn't attainable for people.

If something was a really good intervention but would cost a lot of money, we wanted that kind of feedback to make sure that everything that we were putting in there was actually going to be used. We tried to get feedback from C-suite leaders, wellness leaders, HR, clinical leaders, everybody across a hospital or health system setting just to make sure that we were getting that broad spectrum. Then, as Rebecca mentioned, we published this in September 2022 but before moving on to like the next phase of our work.

One thing that we think is really unique about this guide and that we're really proud of is that I know Rebecca mentioned at the beginning, a lot of the research and work that has been done in this space has been really historically focused on physicians and nurses. We do know that those populations have a high risk, but we also know that there are a lot of other people that work in hospitals and health systems, and we're really proud that I think we made this as holistic as we could. We really tried to take into account what about somebody that works in environmental services, that is during COVID times, going into rooms and having to clean a room that somebody had COVID? What about nutrition? What about administrators?

We really tried to make sure that anything included in this guide could be applied across the hospital. Let's get into the meat of what is actually in this guide. As we've mentioned a few times, we broke this down into three big buckets of work that we called the drivers of suicide. The first one is something I think we

all probably can identify with working in healthcare. It's just that stigma about talking about mental health. People are afraid to bring it up. They don't want to talk about it. They're afraid it could make them look weak, things like that, which we know is not true, but those things do exist.

We really need to make sure when we're talking about healthcare worker mental health that we're thinking about stigma. We know that healthcare workers can be especially fearful about admitting that they need support because we're conditioned to feel like we can handle the pressure of the job. We also know that there's a significant fear from many clinicians about losing their license or their privileging and credentialing. We know that there are many states and organizations that are working toward mitigating this problem.

I think since the beginning of COVID, we've seen a huge positive jump in the way that states and different healthcare organizations are addressing this. It makes sense that if you admit that you have something going on with your mental health or you need support, but you can lose your job because of that, you're probably not going to admit that you need help. That is what we've found to be a very foundational piece of this stigma conversation. I'm happy to answer any questions or point you in the right direction on some resources around that if you're curious.

Liz: I put in the chat, the link to the Dr. Lorna Breen Heroes' Foundation's toolkit around licensure and credentialing. We've had Corey and team and folks from the AMA on past Insights Huddles about that topic. It's something we've got additional resources if anyone has questions, but that toolkit is excellent.

Jordan: It is. We worked very closely with the Dr. Lorna Breen Heroes' Foundation on all of this. It all aligns. We're all working together towards the same goal. One other piece that we really heard through these interviews and focus groups around stigma is that clinicians were really worried about seeking treatment at their own organizations because they didn't want to be seeking treatment from their peers. They didn't want to be seen going into a clinic. They didn't want people to know. Even though we know that the provider can't talk about it, they're still afraid that it's going to get out that they're struggling. That's something we really tried to address in our guide as much as we could.

The second driver that we identified in our guide is inadequate access to behavioral health education, resources, and treatment. We know that this is not because people and organizations don't want to provide this, but we know that it can be difficult. We really saw two main issues related to the issue of access. The first one is just people couldn't get the help they needed when they needed it. You could have all of these great interventions, great programs at your hospital or health system, but if they can't accommodate a provider's schedule that works on the night shift, if there's a really long wait to access care, if they're worried about the confidentiality issue I just mentioned and somebody is going out of network to seek care, that can all cause issues for getting that access in a timely way.

The second issue is maybe the flip side of that, is that even if you've got all of this good stuff, people don't know how to get to it. We make it really hard on people and Rebecca and I have even looked through our AHA resources as we were going through this and just saying, how does somebody get to our EAP? How does somebody get to our mental health resources? We don't think about how difficult it is, especially if somebody is in crisis, so making sure that things are really, really easy to find and easy to access and also confidential when they do access them is really important to healthcare workers.

Our last driver that we included in the guide, I think that this one, usually when I present this, I say doesn't need a lot of explanation. You all work in hospitals and health systems. We all know what it means to be a healthcare worker. It can be a tough job. There's no sugarcoating that, but even if we can't take away some of these just inherent job-related stressors that exist because you work in a hospital or because you are a healthcare worker, what we can do is make sure that we have the appropriate supports in place to help people deal with some of these things.

We can't maybe eliminate repeated exposure to death and dying as a healthcare worker, but we can make sure that people are supported when they are dealing with those things.

Rebecca: Hey, Jordan, if I can jump in before you deep dive into the interventions. I've put a resource related to each of the drivers in the chat. The one related to stigma, it's called People Matter, Words Matter. It's an initiative that's about two years old now, and it is a series of posters that anyone on this call, this is full game for anyone out there. In fact, the city of Philadelphia and the city of Baton Rouge are both using them. It's our attempt to help educate, internally, our workforce on how to speak about difficult subjects. The most recent one that we released is how to ask the questions of your own peers. People are afraid to say, "You seem off. Are you okay?" and really get into that. It's a series of posters. One is on suicide. One is on addiction or substance use disorders. Another is related to PTSD. People first language. Just take a look at those and feel free to use them in your own organizations. Then the resource related to access, there is a workbook. It's ever evolving but on recruitment and retention strategies for healthcare workforce. The first three chapters of that are related to things like burnout, so it relates to driver three, job-related stressors.

In terms of behavioral health, there's a great deal of information where we are asking our C-suite leaders to say, "Look at your own health plans. Are they compliant with the parity law? Do they have adequate network coverage? What are the penalties for out-of-network care?" Take a look at that. Then the third one that I put in, many of you may be familiar with this. I know certainly ChristianaCare is, but even before COVID, we had created through our boss, Elisa Arespacochaga, leading it, our physician wellbeing workbooks. There are a lot of ideas there related to reducing job-related stressors and burnout. We were already on our journey on this work, but I wanted to make sure you had access to those as well.

Liz: Thank you for sharing them.

Jordan: Thanks, Rebecca. As we alluded to at the beginning with all of this, the guide includes 12 evidence-informed interventions that we associated with at least one of the drivers that I just went over, but most of them, because they overlap so much, go with more than one. We've also grouped the interventions in the guide by type. We have interventions around increasing access to services, operational enhancements. What are some of those leadership things that can be taken on to make significant change in this area? The third is organizational campaigns. How can we really talk about this across the hospital or system and make it more well-known that we're addressing this issue?

Then the fourth is training. Just how can we increase that capacity in our own workforce to address some of these problems that we're all experiencing? I'm not going to go through each intervention now. There's a lot more information in the guide. As I mentioned, we included outcome measures for each intervention, so you don't have to think about that if you're going to try one of these. We included some information about how to measure your success, additional resources around each of these, things like that. I'll turn it back to Rebecca.

Rebecca: Before I go on, I just want to say I heard Corey Feist say that right now, even when you change the state licensure laws or your credentialing questions, you really have to work extraordinarily hard at the communication campaign to make sure that every one that is impacted by the positive changes in the question realizes that the changes have happened and understand the implications because there is some reality that Dr. Lorna Breen might still be with us, given what existed in her state, had she known, had she been aware, and she is not the only one.

If you are on that journey, I would just truly emphasize the communication campaign. That's something that working with the Dr. Lorna Breen Foundation and as part of the AllIn group, we are continuing on that journey. Year two. We said to the CDC, and they were in agreement, this is really good information, but now what? We don't want this to just be a guide that sits on the shelf or in this case, on your laptop somewhere. How do we take it to the next generation?

Thankfully, they said, we will fund you, as I mentioned earlier, for one more year. Next slide. We actually recruited originally 42 organizations to this six-month collaborative. We felt it was really good. At the end, we still had 37. It was a 90% retention rate. When I say 37 participating organizations, one of them was Common Spirit. For those of you who know how large that entity is, that's many more hospitals than one. Providence was another. It was a mix of large health systems, community hospitals. We had a VISN, a series of VA hospitals out on the West Coast in California. There were rural hospitals. There was one children's hospital.

We really were proud of the diversity of the hospitals and health systems that we recruited and retained throughout the six-month. How those individual hospitals and health systems chose to participate varied. Some of the larger or multi-state health systems or multi-hospital systems said, "We're just going to start small. We're going to see how we can roll this out at one of our member organizations." Others said, "We're going to try to go across the board." We left that to them because they know their systems and their organizations best.

How did we recruit? Many of the organizations that we recruited, they responded to one or more of our surveys in year one. We shared across the AHA network of professionals and at our membership meetings per se. We were very lucky with the recruitment. Next slide, please. Jordan is going to go into this, but what came out of this? We had developed 18 new case studies showcasing the successful projects from the organizations in the collaborative. The very last slide, and I think you will have this deck if you don't already have it already, Liz is saying yes.

The very last slide in this deck has hyperlinks to the websites where you can go and dig a little deeper as to what a number of these organizations did. You can see fairly successful social media campaign. 83% of the organizations said they actually made progress during this six months. Six months is not a lot. It's not a lot of time when you really start trying to change culture and really make an impact, so we were pleased with that. Then, as you can see, we mentioned Lorna Breen several times and the need to change the questions so that they don't discriminate.

10% updated them and many more were updating them and continue to do so. I'm not sure if it's ongoing now but for several months post-project, this ended in October of last year, these organizations continued to meet on their own because they wanted to continue to learn from each other and also have each other hold up and continue challenge. Are you going to keep working on this very important issue? How can we continue to support each other's work in doing so? Next slide, Jordan. I think it's over to you.

Jordan: It is. This group does continue to meet. We're about, I'd say, once a quarter right now. We've been going back and forth on once a quarter versus every other month. If anybody on this call is interested in attending those or sending somebody from your system or hospital to sit in on those, we welcome new members to that. They're pretty informal calls but just a chance for people to come together and talk about issues they're having and troubleshoot and just work together. You could just put your email in the chat or reach out to me and I'm happy to get you connected to that.

Just elaborating on that first piece that Rebecca brought up about the case studies. We did get about half of our participants to submit a written case study to us about the work that they did. We found these to be really valuable in sharing with other organizations just to get the juices flowing and to get some inspiration going on things that they could implement in their own organizations. We've got a great website that is linked here. I encourage you to check it out. It houses all of those case studies. Then also just a brief, if you're curious about some of our other outcomes from the project that I'm not going to go through.

I would like to spend a few minutes now just talking through three of the project examples that came from these case studies. If anybody is from one of these organizations on this call, kudos and please speak

up so we can hear from you know of anything that I don't about it. They're three very different examples, but just like I said, to maybe get some inspiration moving. This is probably my favorite example that came from the collaborative. It came from Atlanta Care Regional Medical Center. What they did was so low cost. All it took for them to do this was just staff time, which I think is really important in today's climate.

What they did is they created screensavers on all of their network computers that house suicide prevention and behavioral health resources. Every time somebody sat down and tapped in or tapped out, open Epic, write a note, do whatever they were going to do, those resources were front and center in front of their face every single day. This was an idea from their suicide prevention coordinator for their system, but she partnered with many people across the organization. She had great leadership buy-in on this. She worked with IT marketing to design some of those graphics and things like that.

I think what's so great about this is that it was just a passive intervention. People didn't, I think, even realize all the time that they were seeing those resources over and over all day, every day. They also included some of that matching graphics and communications in 20 all-staff communications over six months. Those were emails, newsletters, on the intranet, things like that. People were seeing this information constantly and across a lot of different platforms. That was really, I think, important for them in decreasing the stigma because they were just seeing it everywhere.

They ended up seeing an increase in utilization of their resources throughout the six months, which I think speaks so highly to this intervention and this idea. I think this is something everybody on this call could probably do at their own system or hospital because like I said, it didn't take a ton of time or effort to implement and manage this. I think this is an awesome example to share with people.

The next example that really focused in on the issue of increasing access to care came from Common Spirit. As Rebecca mentioned, they are a very, very large health system. I think they told us they have about 150,000 workers across 145 hospitals in 24 states. I believe that's correct. They've gone through a lot of mergers. They've been expanding and expanding and expanding. They realized after they sat down and looked at some of their resources, that they had 13 different EAPs across their organization, which I'm sure that happens a lot.

They really wanted to make it easier for their employees to access the ample amount of resources that they already had. They sat down, they created a cross-system team that was multidisciplinary, and they consolidated their EAP benefits to one vendor. They made that a more equitable situation across all of their sites of care and their hospitals to make sure everybody had the same access. Then they also introduced a digital hub for all of their wellbeing resources. Instead of having it hidden in their intranet or things like that, they created something that was very, very prominent where people could just go in and click and get everything that they needed.

Then I think a common thread through all of these different interventions that we've talked about is that integrated communication plan about what you're doing because if you do all this great work and nobody knows about it, you're not going to see an improvement in utilization. I think that's another really great thing. They didn't have to implement something completely new but really just pausing, taking a step back and saying what are we actually offering, I think proved to be very beneficial to them. That's why I like to share this example.

Liz: Then, Jordan, again, before you move on, I just want to remember a learning from last month's Insights Huddle, which was looking at balancing security and connection, some more responses to workplace violence. I think there's still a learning here that's interesting, which is that one of the organizations had their EAP folks actually rounding on units so that these weren't unknown. Sometimes EAP itself has a stigma associated with it, so bridging the divide between EAP and frontline folks by having them round, not when a crisis happened, but just as a, "Hey, here we are. We're with you. We're

supporting you, listening as well." I think that can help in this kind of a situation where folks might be reluctant to reach out to that kind of resource, but when there's a known face to it becomes easier to access.

Jordan: I'm glad you brought that up, Liz. Thank you. We know from our AHA data that 99% of hospitals and systems have an EAP of some kind, and I think it is significantly underutilized at most places. Yes, getting it out there as much as you can, that this is not a scary thing, there are people on the other side of that phone that want to help you and are there to help you, I think is a huge benefit. All right. Our last example comes from Geisinger. They took a different approach to this where they created something completely new, and it addressed a lot of different stressors across the organization.

They've got a great case study about this that has a lot of information, more than we can fit into this slide. They created something called a Personnel Crisis Response Team. They were trying to respond to things like workplace or community violence that happened, maybe if there's a tough patient or family situation that clinicians are having a hard time dealing with or security staff had a hard time dealing with, things like that. Maybe somebody made a patient safety error, any kind of thing that could really disrupt the way that they're providing care to patients.

Basically, what they did is they took their entire leadership team and trained them on responding to some of these different incidents. They called that person that was on call for the day, the PCRT coordinator. Basically, they were the centralized person across the system that was contacted, and they were responsible for bringing people together and formulating a plan of action. They really wanted to make sure that whatever was happening in the system or in the hospital that day, despite that, wanting to get the person help and make sure that they were emotionally taken care of but also that they were still managing risk and safety in other areas of the hospital and continuing business as usual as much as they could, again, while still taking care of those people that were affected.

Leaders, like I mentioned, rotate as the responsible person on this, so they all have that buy-in across the board. Then one thing I think is great for addressing some of this job stressor piece specifically is this program incorporates regular follow-up with the people who were affected for as long as they need. They said most of the time, it's a few weeks that they follow up and make sure the person is okay, but if it was a really significant incident and people need more support, they are going to follow that provider or that employee as long as they need to make sure that they're getting connected to resources as they need. I thought that was just a really proactive response and again, something I think that if you have the ability, it's a really good thing to think about and consider.

Liz: Yes, just to plant a seed and follow up to that, Jordan, I love that example. We've worked with a lot of organizations around Code Lavender programs, and they often will have a Code Lavender, which is a lightweight intervention, and then a critical incident response team. I love the difference there of having the senior leadership play that coordination role. First of all, there's that visibility. Second of all, there's the recognition that this is really important. Third, that rotating responsibility means that it stays on the radar screen as a commitment to team member wellbeing. That visibility of the senior leaders, I think, is really valuable.

Jordan: Absolutely. It's housed within their wellbeing. They have a chief wellbeing officer who oversees this program and then a team that helps to implement it. I think that, like you said, having that buy-in from across the organization and not having it just come from one place has been really helpful for them. Happy to connect and learn more or tell people more if they're curious about that program specifically. As we wrap up, I know Rebecca has been putting some resources in the chat but just want to make sure you have all of these specific things we've put out over the last few years. If you go to our website, we have the guide, all the case studies I mentioned. Also, a lot of just educational content that you can share with your teams. We've seen people use some of these podcasts, videos, things like that to start conversations around this topic, with managers showing this to their teams or things like that. Please

explore those. We've got a lot of great stuff out there, and we're happy to answer any questions or send you in the right direction if you're looking for more.

Then you have our contact info if there are any further questions, but I think we probably have time to answer some now. Thank you.

Liz: Thank you, Jordan and Rebecca. That was super helpful, and I do invite people to jump in with questions or with examples or stories that either reinforce or add to what Jordan and Rebecca have shared today. I see some names on the line where I know this has been something that your institution has grappled with. Would anyone like to jump in?

Rebecca: While we're waiting for the first person to jumps in, I will just say, tying back to the comment that Jordan made earlier about our guide, our work, we really wanted to be able to go across and beyond and embrace the whole hospital and health system family. If you look at the three examples that she gave, the one on stigma, everyone who logged in, didn't matter, if you are logging into the computer in that organization, you're seeing those resources. In terms of the job stressors, it doesn't matter who was impacted. It cuts across the whole organization. Each one of those examples cuts across the whole organization and doesn't focus just on one. We were really proud to see that what we had hoped to have happen was happening in real time during the collaborative.

Liz: Thank you, Jordan. Thank you, Rebecca. Thank you to all who participated. We will follow up with a summary email including all of the links that have been in the chat, the slides, and anything else. Then, as you heard from Rebecca and Jordan, they are both very open to any other outreach that you would like, and we're grateful for your partnership on this. Thank you for taking the time, and thank you all for continuing to care for your team members.

Thank you to all of our Insights Huddle speakers and participants. We don't share the discussion portion of Insights Huddles publicly, so we can foster a safe environment where participants can be candid and share vulnerable and valuable experiences. Insights from the group discussion are summarized in the recap with supporting resources.

If you have questions about this topic or have an idea for a future Insights Huddle to help improve the safety and wellbeing of team members, email us at HeartofSafetyCoalition@stryker.com. You can also sign up to join Insights Huddles live on the Heart of Safety Coalition website.

About the Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety and wellbeing at the heart of healthcare. This national community of leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systematic and individual change. The Coalition works to advance the Heart of Safety Declaration of Principles, which intersects health justice, physical safety, and psychological and emotional wellbeing to accelerate transformation. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www.HeartofSafetyCoalition.com.