Appendix A. Detailed Intervention Implementation Process

Prehospital Emergency Services Professionals

This population consisted of emergency medical technicians and paramedics working in a prehospital and interhospital system. The participating prehospital emergency medical services systems engaged in patient contacts via two types of emergency medical services provision: patient contact via the 911 emergency response system, and patient contact via ground transportation requests from the critical access hospital to other healthcare facilities (e.g., transfer to a tertiary care center via ground, discharge to long-term care facility, etc.).

The following types of patient contacts generated follow-up summaries for participants:

- Patient contact in which the patient was transported via emergency medical services from scene to the emergency department located in the critical access hospital partner.
- Patient contact in which the patient's care was transferred to air transportation in the field (e.g., severe trauma with flight directly to an outlying trauma center).
- Patient contact in which the patient was transferred from the critical access emergency department to another acute care facility (e.g., transfers to a tertiary care center).

The following types of patient contacts did NOT generate follow-up summaries for participants:

- Patient contact via the 911 emergency response system that did not result in transportation (e.g., lift assist calls).
- Patient contact in which the patient refused emergency medical services care.
- Patient contact in which the patient's care was transferred to a facility that did not participate in electronic health record data sharing with the critical access hospital. Note: emergency department summaries from the critical access hospital were provided if patients in this category were stabilized in the critical access emergency department prior to transfer to a tertiary care center that did not participate in data sharing.
- Patient contacts in which the patient was to be discharged from the hospital but not transferred to another acute care facility (e.g., discharge to nursing home).
- Patient contact in which the patient was admitted to a psychiatric facility.

Hospital-Based Emergency Services Professionals

This population consisted of nursing staff working in an emergency department setting.

The following types of patient contacts generated follow-up summaries for participants:

- Patient contact in which the patient was admitted to an inpatient hospital setting AND in which a discharge summary was available following the patient's hospital discharge.

The following types of patient contacts did NOT generate follow-up summaries for participants:

- Patient contact in which the patient was admitted to an inpatient hospital setting but in which a discharge summary was NOT available following the patient's hospital discharge (e.g., the patient was admitted to a hospital that does not participate in electronic health record data sharing with the critical access hospital and the discharge summary was therefore not available).
- Patient contact in which the patient was discharged from the emergency department to home or a long-term care setting.
- Patient contact in which the patient refused care, left against medical advice, or eloped.
- Patient contact in which the patient was admitted to a psychiatric facility.

Follow-Up Process

The electronic health records were audited once weekly by one member of the research team to identify patient contacts by study participants that met the above criteria, using an automated query process. Two queries were performed: one in the prehospital electronic health records to identify the relevant patient contacts by prehospital emergency services professionals enrolled in the study, and one in the hospital-based electronic health record system to identify relevant patient contacts by hospital-based emergency services professionals enrolled in the study. Prehospital emergency services professionals were identified as a member of a given patient's care team if their name was listed as one of the responders in the electronic health record. Hospital-based emergency services professionals were identified as a member of a given patient's care team if they had been assigned to a patient's emergency department encounter at any time (e.g., if one participant was assigned to a patient, then another participant was later assigned to the same patient due to a shift change, both participants would receive a follow-up summary on the same patient).

Following identification of relevant patient contacts and the number of ESPs who should receive a follow-up from the given patient contact, one copy of the patient's discharge summary was printed, folded, and taped closed per participant (e.g., if one patient contact was associated with three study participants, all three participants received a copy of the discharge summary). The discharge summary contained all of the following information: (1) the patient's diagnosis from the encounter, (2) treatment course summary, (3) disposition from the emergency department and/or hospital (e.g., discharged home, deceased, admitted, transferred to another facility, etc.).

Paper discharge summaries were delivered to participant via interdepartmental mailboxes. Participants were instructed to shred or otherwise destroy the patient discharge summaries immediately following their review of the documents to comply with regulations governing the destruction of protected health information.

Appendix B. Survey Instruments

Professional Quality of Life Scale

Measures compassion satisfaction, burnout, and secondary traumatic stress, developed by Stamm (2010). The instrument is open-access and free for public use.

Instructions: When you care for people you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as an emergency services professional. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	Never	Rarely	Sometimes	Often	Very Often
1. I am happy.*					
2. I am preoccupied with more than one person I cared for.					
3. I get satisfaction from being able to care for people.					
4. I feel connected to others.*					
5. I jump or am startled by unexpected sounds.					
6. I feel invigorated after working with those I care for.					
7. I find it difficult to separate my personal life from my life as an emergency services professional.					
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I cared for.					
9. I think that I might have been affected by the traumatic stress of those I care for.					
10. I feel trapped by my job as an emergency services professional.					
11. Because of my work as an EMS professional, I have felt "on edge" about various things.					

12. I like my work as an emergency services professional.					
13. I feel depressed because of the traumatic experiences of the people I care for.					
14. I feel as though I am experiencing the trauma of someone I have cared for.					
15. I have beliefs that sustain me.*					
16. I am pleased with how I am able to keep up with care provision techniques and protocols.					
17. I am the person I always wanted to be.					
18. My work makes me feel satisfied.					
19. I feel worn out because of my work as an emergency services professional.					
20. I have happy thoughts and feelings about those I help and how I could help them.					
21. I feel overwhelmed because my work load seems endless.					
22. I believe I can make a difference through my work.					
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I care for.					
24. I am proud of what I can do to care for others.					
25. As a result of my emergency services work, I have intrusive, frightening thoughts.					
26. I feel "bogged down" by the system.					

27. I have thoughts that I am a "success" as an emergency services professional.					
28. I can't recall important parts of my work with trauma victims.					
29. I am a very caring person.*					
30. I am happy that I chose to do this work.					

Scoring: Never = 1, Rarely = 2, Sometimes = 3, Often = 4, Very Often = 5. Reverse-coded items are noted in the table with a * and are instead scored Never = 5, Rarely = 4, Sometimes = 3, Often = 3, Very often = 1.

Compassion satisfaction score = Sum of items 3, 6, 12, 16, 18, 20, 22, 24, 27, 30. Minimum score of 10, maximum score of 50 points is possible.

Burnout score = Sum of items 1, 4, 8, 10, 15, 17, 19, 21, 26, 29. Minimum score of 10, maximum score of 50 points is possible.

Secondary traumatic stress score = Sum of items 2, 5, 7, 9, 11, 13, 14, 23, 25, 28. Minimum score of 10, maximum score of 50 points is possible.

Feasibility, Acceptability, and Appropriateness Instrument

Measures feasibility, acceptability, and appropriateness adapted from Weiner et al. (2017).

Please rate your agreement with the following statements:

	Completely Disagree	Disagree	Neither Agree nor Disagree	Agree	Completely Agree
1. Receiving patient follow-up communications meets my approval.					
2. Receiving patient follow-up communications is appealing to me.					
3. I like receiving patient follow-up communications.					
4. I welcome receiving patient follow-up communications.					
5. Receiving patient follow-up communications seems fitting.					

6. Receiving patient follow-up communications seems suitable.					
7. Receiving patient follow-up communications seems applicable.					
8. Receiving patient follow-up communications seems like a good match.					
9. Receiving patient follow-up communications seems implementable.					
10. Receiving patient follow-up communications seems possible.					
11. Receiving patient follow-up communications seems doable.					
12. Receiving patient follow-up communications seems easy to implement.					

Scoring: Completely Disagree = 1, Disagree = 2, Sometimes = 3, Agree = 4, Completely Agree = 5.

Acceptability score = Sum of items 1-4. Minimum score of 4, maximum score of 10 points is possible.

Appropriateness score = Sum of items 5-8. Minimum score of 4, maximum score of 10 points is possible.

Feasibility score = Sum of items 1-4. Minimum score of 4, maximum score of 10 points is possible.

<u>Satisfaction of Employees in Health Care - Global Job Satisfaction Subscale</u>

Rate the following according to your primary job in emergency services:

I would recommend this health facility to other workers as a good place to work.	Definitely No 10	Probably No 33	Probably Yes 66	Definitely Yes 100
How would you rate this health facility as a place to work on a scale of 1 (the worst) to 10 (the best)?	10 20 30 40 50 60 70 80 90 100 Worst……..……..Best			

Score is calculated as the mean of both items. Minimum score of 10, maximum score of 100 points is possible.