**If you build it they will come: How the roll-out of a large, consistent second victim program unmasked an underlying need for broader peer support.**

**Objectives**: Participants will be able to identify three core elements in establishing a consistent second victim program and anticipate potential unmet needs of physician colleagues.

**Background**: While it is impossible to place a monetary amount on the emotional suffering of a provider, simple estimates suggest that having an effective second victim program could save healthcare systems millions of dollars. The goal of our program was deployment of a comprehensive second victim program in a consistent and sustainable manner to address the emotional needs of a second victim.

**Methods:** In a complex integrated health-care system we deployed a second victim program based on the three-tier system developed by Scott at University of Missouri. To ensure sustainability and consistency we developed a program-wide ‘evolving’ playbook containing a step-by-step process of strategies used to implement a second victim program within our system. We created a basic architecture by identifying two physician leads and a program manager in each of our thirteen geographic areas. Over a two-year period, we educated leads via the playbook, by conducting webinars to answer questions and share best practices, on-site visits to ensure consistency of the programs and full day learning sessions to allow for face-to-face problem solving in the group. In three geographic areas, non-identifiable data was collected regarding the numbers of physicians seeking peer support and their reasons for seeking this support.

**Results**: We analyzed data from these three geographic areas to understand patterns in service utilization. In these areas, there were 139 peer to peer encounters from 2016 through the end of March 2018. Physicians who accessed peer support included second victims; however, we also found the majority accessed the system for other needs ranging from physicians who were victims of direct patient threats to physicians experiencing marital distress. (see table 1).

**Conclusion:** We developed and implemented a second victim program in a complex integrated healthcare setting with consistency.Our preliminary findings indicate that physicians had unmet needs for peer support. In the future we may need to increase our number of peer supporters while adding a broader array of training so they feel confident in their abilities to support a variety of situations. Next steps include collecting non-identifiable follow-up data regarding numbers, gender, career length and type of support needed for second victims in all thirteen geographic areas and identifying areas for program improvement and expansion based on feedback.