ASSESSING WORKFORCE READINESS TO PROVIDE COMPREHENSIVE SUICIDE CARE

September 18, 2018

EDC Learning transforms lives.

Funding & Disclaimer

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Moderator

Julie Goldstein Grumet, PhD
Director of Health and Behavioral Health Initiatives
Suicide Prevention Resource Center

Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention.

Suicide Prevention:
We All Have a Role to Play

The nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention.

www.sprc.org

EDC Education Development Center

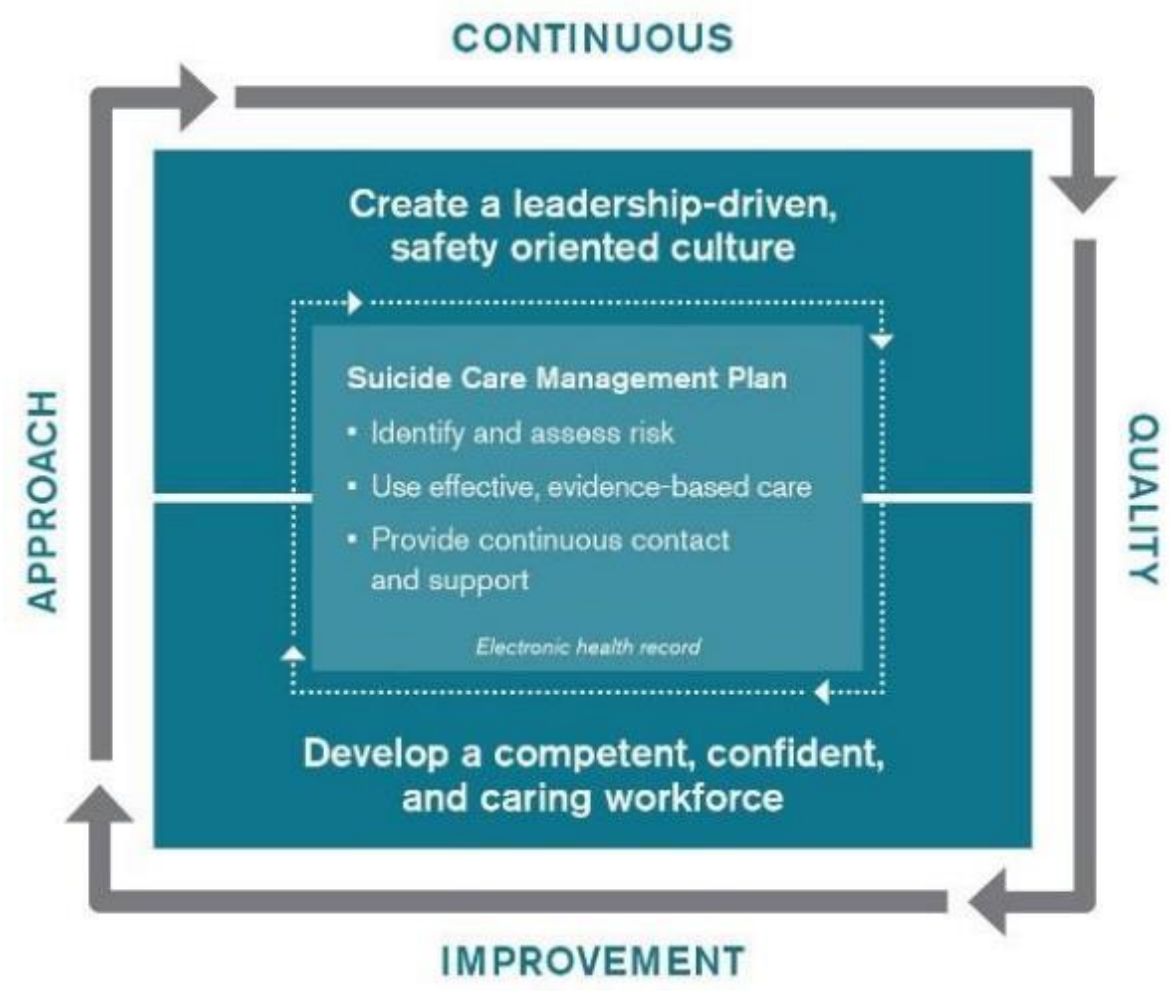
ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

ZEROSuicide…

- is an aspirational goal.
- focuses on error reduction and continuous quality improvement.
- fills in the gaps that exist in suicide care.
- centers evidence-based practices.

ZEROSuicide

A Continuous Process



Workforce Readiness

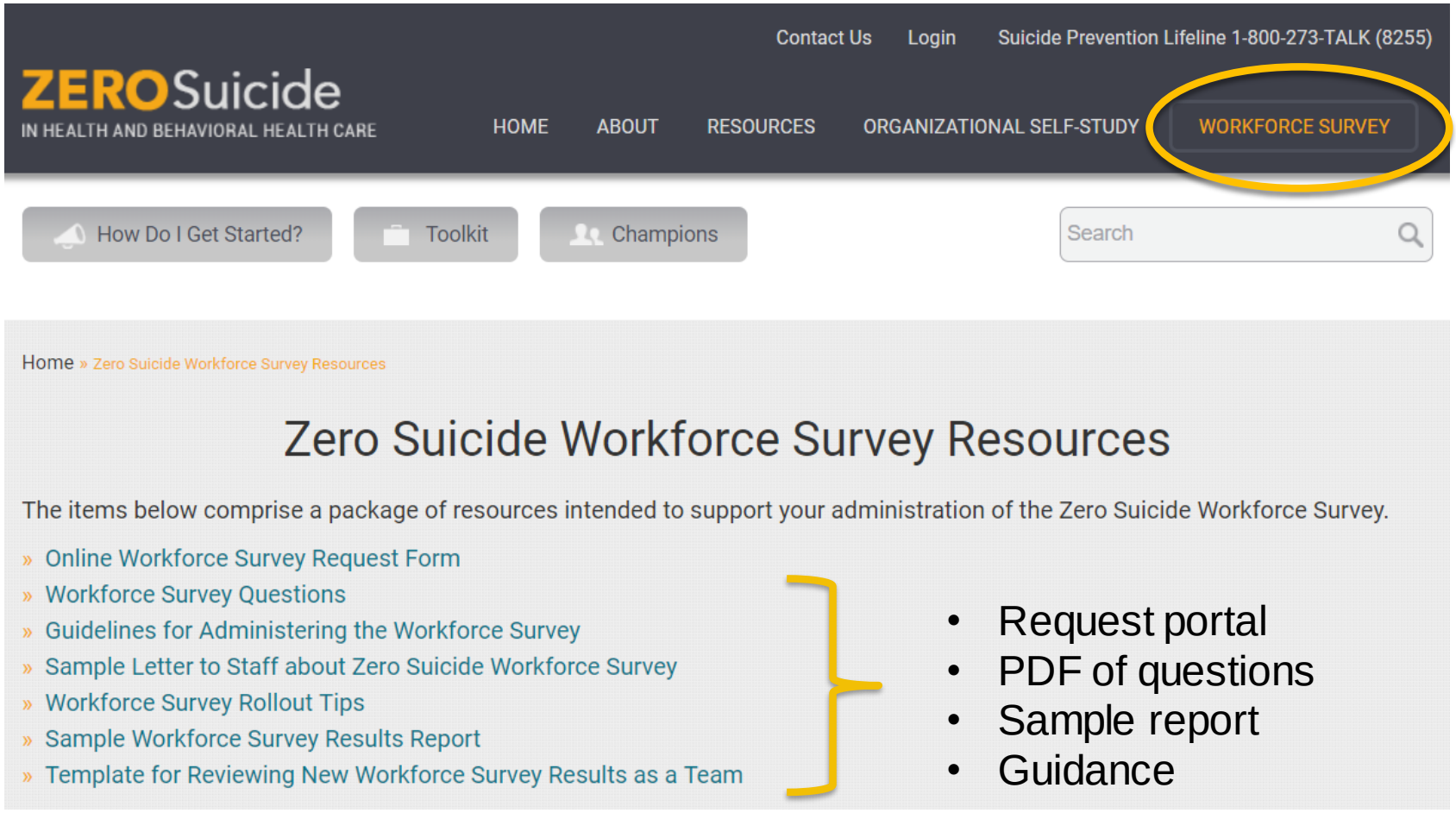
Zero Suicide Toolkit

www.zerosuicide.com

The online Zero Suicide Toolkit offers free and publically available tools, strategies, and resources, plus links and information to:

- Get key implementation steps and research information
- Explore tools, readings, webinars and other public resource
- Access templates from implementers across the country
- Connect with national implementers on the Zero Suicide listserv

Zero Suicide Workforce Survey



- Request portal
- PDF of questions
- Sample report
- Guidance

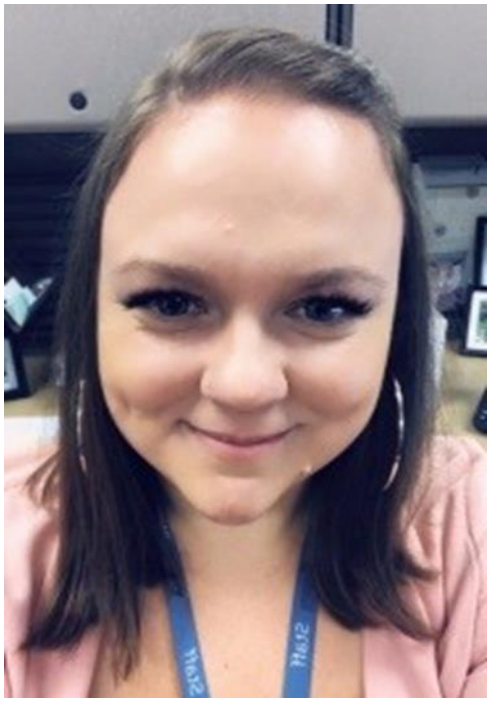
www.zerosuicide.com

Learning Objectives

By the end of this webinar, participants will be able to:

1. Describe how surveying staff can support system-wide culture change critical to patient safety and continuous quality improvement.
2. Understand staff readiness to provide suicide-specific care.
3. Explain the purpose and utility of the Zero Suicide Workforce Survey to health care staff.

Presenters



Katerina Barton
St. Joseph's Health Care

Rob England
United Indian Health Services

Glenn Thomas
Nationwide Children's Hospital

Presenter

Katerina Barton BSc, MA
Project Director
St. Joseph's Mental Health Care

St. Joseph's Health Care London

St. Joseph's Hospital
268 Grosvenor Street

Beds	21
Day Surgeries	21,624
Outpatient Visits	477,668**
Urgent Care Visits	41,592

Southwest Centre for Forensic Mental Health Care
401 Sunset Drive, St. Thomas

Beds	89
Outpatient/Outreach Visits	20,927**

FACTS & FIGURES

Staff	4,000
Physicians*	1,224
Residents/Clinical Fellows, Medical Students*	1,915
Other Health Discipline Students (physiotherapy, nursing, psychology, etc.)	833
Volunteers	942
Beds	1,042
Outpatient/Outreach Visits**	944,424
Day Surgeries	21,624
Urgent Care Visits	41,592

LAWSON HEALTH RESEARCH INSTITUTE

Researchers	151
Personnel, Students and Volunteers	330
Active Research Projects	746

2017/2018 OPERATING BUDGET	$475.3M
Provincial Funding	$329M
Federal Funding	$25.9M
Other Funding Sources	$120.4M

ALL FIGURES SHOWN (EXCEPT OPERATING BUDGET) ARE FROM APRIL 1, 2016 TO MARCH 31, 2017

Mount Hope Centre for Long Term Care
21 Grosvenor Street, London

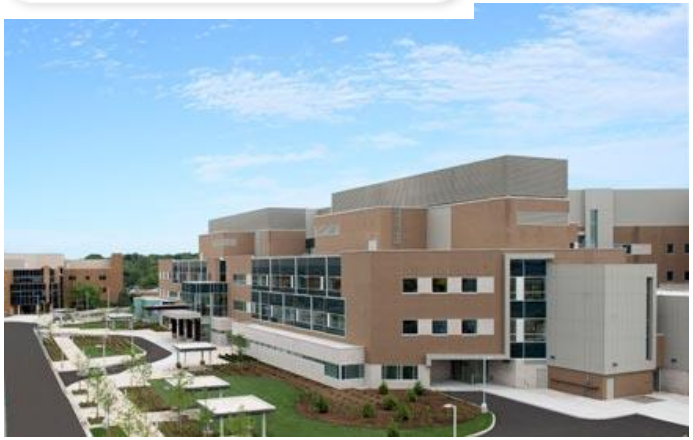
MARIAN VILLA
ST. MARY'S

Beds	394

ST JOSEPH'S HEALTH CARE LONDON

MENTAL HEALTH CARE BUILDING

Beds	150
Outpatient/Outreach Visits	177,839**



Workforce Survey Roll-Out & Response Rates

- Department- and clinical group-specific
  - Consider separate surveys for clinicians/docs/etc.
- Open for two weeks
- Communications:
  - Before: letter from project sponsors/senior leadership
  - During: reminders via email and in-person when possible
  - End: final reminder and push from leader(s)

Enabling Staff to Complete Survey

- Clinical Lead (RN) present on units
  - Helped to step into clinical roles so staff could complete survey
  - Reminders to staff regarding importance of their responses
  - Discussions regarding how the results will be used and benefits to staff (e.g. don't give them training they don't want or need)
  - Sometimes even technical support!
  - Full support from leadership

Results

- Departmental results varied, with some common elements:
  - Feelings of not being supported following an incident
  - Discomfort discussing suicide
  - Fear of triggering patients
  - Fear of professional consequences from colleges/organization

Results

- Results informed training plans
  - Adult Inpatients: risk factors, protective factors, warning signs, mental status exams (MSE), documentation, risk formulation and tools and processes
  - Outpatients: risk formulation, tools and processes, Collaborative Assessment & Management of Suicidality (CAMS)

What Next?

- All results are analyzed by Project Lead and Clinical Lead.
  - Focus on “strongly disagree”, “disagree”, and “neutral”
- Present themes and recommendations to Steering Committee.
- Discuss trends between different departments/units and pulled out areas of focus.
  - e.g. Staff feeling fear following an incident – plan made with Steering Committee to revise the incident review process and standardize the process for making support readily available (commitment from highest levels of leadership).

Surprise!

- Unexpected results:
  - Discomfort with discussing suicide
  - Lack of confidence when assessing and treating suicidal patients
  - Low understanding of organizational expectations
  - Feeling unsupported by organization

Addressing Gaps

- Training plan to address these gaps:
  - Provide basic training on mental status exams and proper documentation
  - Open discussions about the language of suicide (“died by” versus “committed”, etc.)
  - Clear communication of new processes – what was being eliminated and what was being implemented

Communicating Results to Staff

- Staff were shown the results from each survey
- Communicated the themes we pulled out during analysis
- Discussed how we intended to apply the results to their training plan, as well as overall organizational changes (e.g. staff psychological health and safety)
- Made connections between our work and other ongoing projects on the units (e.g. seclusion and restraints, vital cultures)

Follow-Up

- Make clear to staff that they have a (loud) voice in the organization's initiatives.
  - No-blame culture shift
  - Policies being updated to support clinicians after the suicide death of a client
  - Encouragement of their patient-first culture

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Follow-Up

- Repeated survey for Adult Ambulatory program (pilot)
  - Compared results line by line
  - Significant improvement in all areas of focus (comfort, confidence, competence all went way up; further training needs went down)
  - Good measure of quality improvement – our focus is just as much on staff experience as it is on patients'
  - Helped us to connect the dots for staff (you asked for this and we delivered in this way…)

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Next Steps

- Continue with focus on transitions, staff support, culture shifts
- Sustainability plan for training, compliance, and communications
- Collect regular feedback in real time regarding barriers to compliance, any issues that come up, what's working and what's not
- Act on feedback – take to Steering Committee and revise processes as needed

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Audience:

Using the chat box, please share one key takeaway from Katerina's presentation.

Presenter

Rob England MA
Health Promotion Manager
United Indian Health Services

KO'L HO KOOM' MO

WORKING TOGETHER

United Indian Health Services, Inc.

Arcata, California

Potawot Health Village

- Culture is integrated into components of UIHS including the architectural design.
- 7 service sites, 5,282 square miles of rural communities.
- Clinical and Community services.
- 10,911 active clients, represents 6.5% of the Humboldt & Del Norte counties populations.

Our Goal with the Workforce Survey

- Provides vital information on:
  - Staff/organizational needs
  - Areas of opportunity
  - Policy development
- April 2017
  - 171 completed
    - ~70% response rate
- August 2018
  - 198 completed
    - ~76% response rate

Our Approach to the Workforce Survey

- Administration Strategy
  - Paper Survey
  - All Staff Meeting
  - Early Access to Surveys
  - Incentives
  - Team Roles For Survey Collection
- Leadership Buy-in
  - All employee email
- Survey Modifications
  - Working directly with SPRC

Communicating Results to Drive Change

- Interpretation of findings = voice in creating changes
  - Areas of Opportunity
  - Neutrals, Disagrees, Agrees

- Communicating results
  - Leadership & Staff
  - Community

Audience:

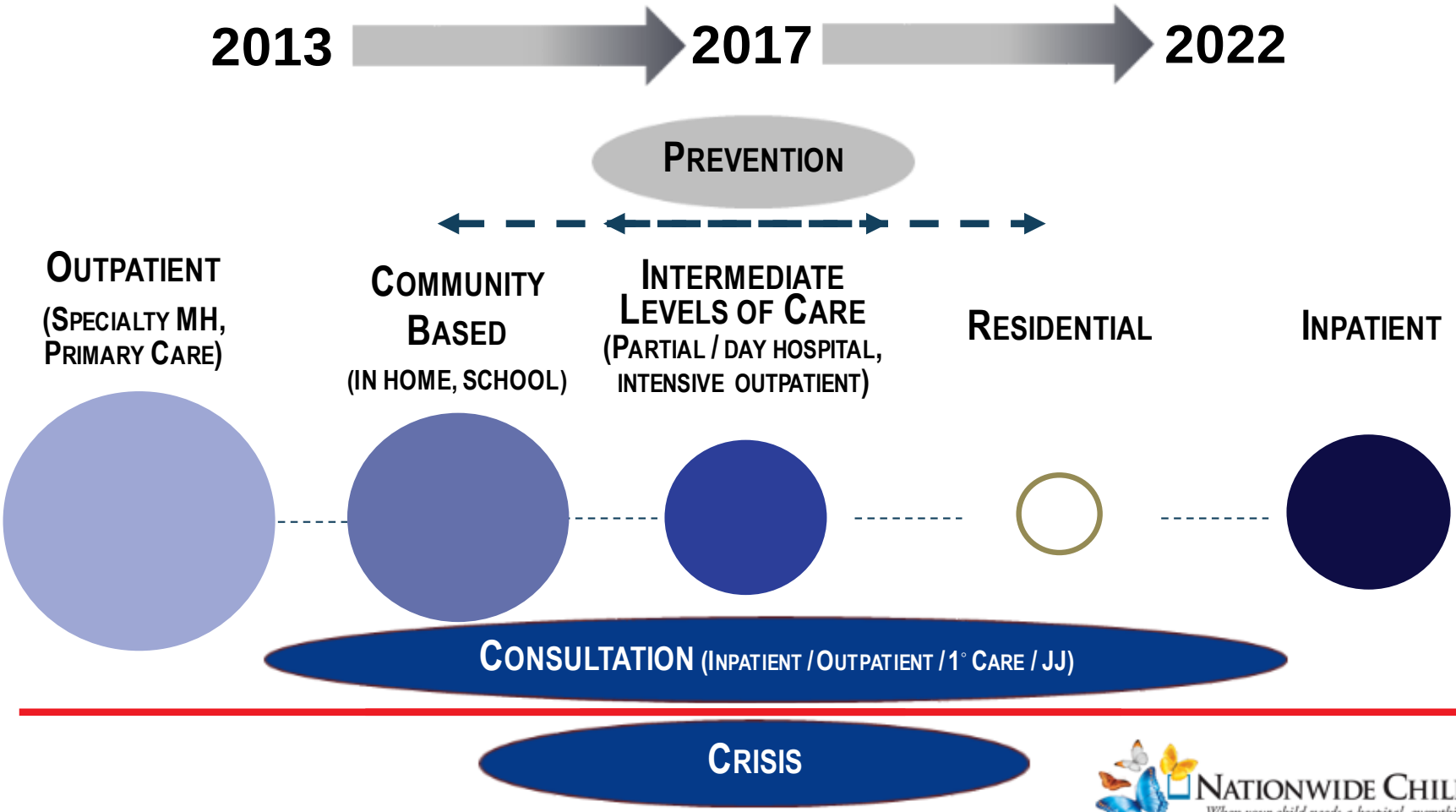
Using the chat box, please share one key takeaway from Rob's presentation.

Presenter

Glenn Thomas PhD

Director, Behavioral Health, Nationwide Children's Hospital
Adjunct Clinical Assistant Professor, Department of Psychiatry and Behavioral Health, The Ohio State University

Nationwide Children's Hospital Behavioral Health Service Care Continuum



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

Rollout

- Implementation team
- E-mail introducing Zero Suicide from the Medical Director to all BH
- Training leadership
- Expanding implementation team
- E-mail introducing Workforce Survey with detailed instructions

Nine Categories

- Psychiatry
- Intake
- Outpatient
- Community-based/intermediate programs
- Pediatric Psychology/Child Diagnostic Center
- Center for Autism Spectrum Disorders
- Crisis/inpatient services
- Operations
- Other Unit/Department

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Dissemination of Results

- Implementation Team review
- Leadership briefed
- Leadership of each area responsible for conveying to staff
- Easy tie-in to Zero Hero
- Monthly Implementation Team meetings
- Loss of momentum addressed

Next Steps

- Screening across the service line (pilot initiated)
- Updating risk assessment and Epic build
- Training on risk assessment and safety planning
- Suicide Care Pathway

Audience:

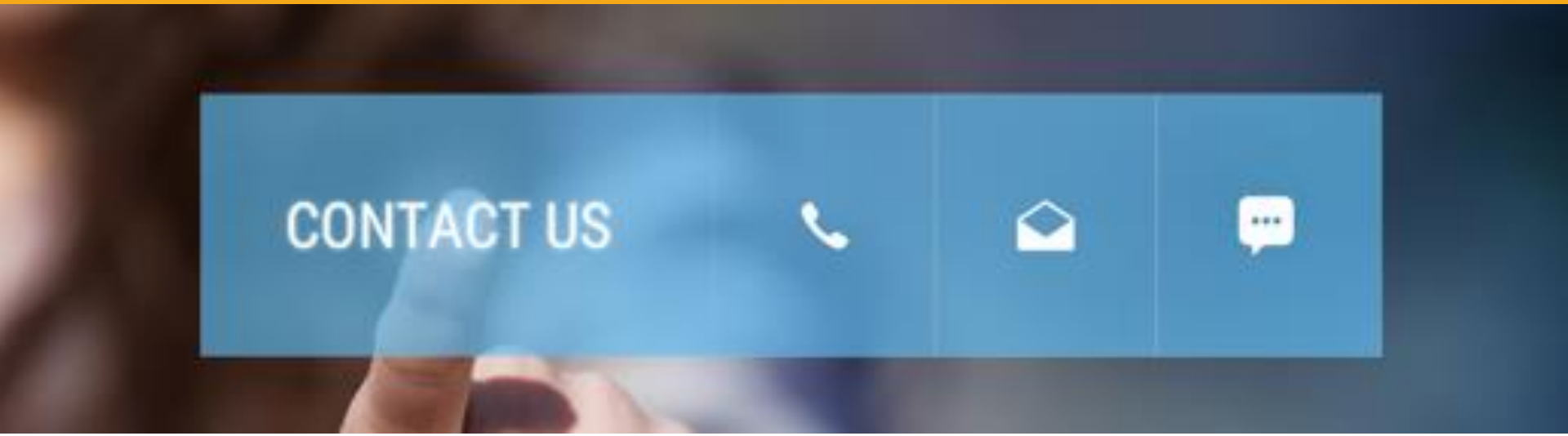
Using the chat box, please share one key takeaway from Glenn's presentation.

Audience:

Type in the Q&A box:

What questions do you have for our presenters?

Contact



Zero Suicide
Suicide Prevention Resource Center
EDC
zerosuicide@edc.org

RAW FILE
EDC
SEPTEMBER 18, 2018
11:45 A.M. CST

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Monument, CO 80132
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+001-719-481-9835
Www.captionfirst.com

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>> CHELSEA PEPI: Okay. So we are at 12:58. We have 177 people that are logged in or trying to log in. Would you like to open the room now?

>> I need about 20 seconds.

>> CHELSEA PEPI: Okay. Let me know when you are ready.

>> I will write in the presenter chat. Give me 20 seconds. Okay?

>> CHELSEA PEPI: Okay. Okay. We are opening doors.

>> JULIE GOLDSTEIN GRUMET: Good afternoon or good morning to some of you. Welcome to today's webinar. We want you to introduce yourselves in the chat. Please let us know where are calling from, your city, your state what organization you are from. Today's webinar is assessing workforce readiness to provide comprehensive suicide care. We have a suite of webinars that are archives. I see that multiple attendees are typing. Welcome. Center stone of Illinois you have been a tremendous leader. Now it is going to fast I can't possibly read. I see

Boise, Idaho. I am going to have to pause for a moment. This is great. I love the diversity where everyone is from. I see Kentucky. I know we have done a lot of work in Kentucky and New York. It looks like we have a more urban settings representative. Texas in big capital letters. Thank you for joining us. Texas was one of the early adopters for Zero Suicide. I see Michigan and New Mexico. I see somebody from Silver Springs, Maryland. You might be a neighbor of mine. I see Florida and North Carolina. I hope that people are doing well after the storm. I am happy that you are able to join us today and hope that you are recovered. The mentor network and Department of Veterans Affairs. These are great. I love to see the diversity and the types of systems that are looking to use these resources and to learn more about preparing the workforce and suicide prevention and I hope throughout today's webinar you will use the chat feature to kind of expand on how today's webinar is impacting your next steps or how you have begun to think about preventing suicide and how we can all learn from you.

So we are going to give maybe one more minute before we get started to let our -- let people in to the room. And let the last few people join us today. But I'm thrilled that you are able to join us. As a check you are in the assessing workforce readiness to provide comprehensive suicide webinar. I am Julie Goldstein Grumet. And this is one of many webinars that we do to really promote different components of the Zero Suicide framework. Lessons that we have learned from all of you that help you to dye deeper in to one of the components.

So thank you all so much for joining us. I think we'll go ahead and get started. I'm going to turn it over for a couple of technology tips.

>> Thank you, Julie. Good afternoon or good morning, folks. My name is Chelsea Pepi. I am with the suicide prevention resource center. All phone lines will be muted for the duration of the meeting. If you have any questions or comments throughout the duration of the meeting, type them in the chat box located on the right-hand side of the screen or the Q and A box which will show up later which will be located on the left side of your screen. We will be recording this meeting and the slides will be available after the presentation on zerosuicide.com. Thank you very much and I will pass it back to you Julie.

>> JULIE GOLDSTEIN GRUMET: Great, thanks so much. So today's webinar is the assessing workforce readiness to provide comprehensive suicide care. It is a suite of webinars that we have conducted. This will be available within the next two weeks. This is just a reminder the suicide prevention resource

center is funded by SAMSHA the opinions and content shared here are our own and don't reflect those of SAMSHA or Department of Health and human services. That's me. I am the director of zero suicide institute. Working with a great team to lead all of our work around improving suicide care in health care systems and with health care providers. If you Tweet please use hashtag Zero Suicide. We have a strong community that helps spread what we are learning. Tweet today and follow that hashtag in the future. The SPRC is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. SPRC a tremendous clearinghouse of resources across settings. We promote collaboration among a variety of organizations in the field of suicide prevention, we have a very robust online training library and journal articles that you can sort according to the different sets in which you work and we also have a variety of resources available around improving suicide care and health care.

So I want to start by giving a brief introduction to what Zero Suicide is if you are not already familiar with it. Zero Suicide is an aspirational goal. Not everyone loves the name Zero Suicide. We have set goals to reduce suicide. And it is noble and it is very, very difficult work. But is it sufficient? How do we feel for aiming for anything less than zero? I think that's why we have to be comfortable with calling the zero Sue side. It is a goal but there is no other goal we should settle for when it is people in our care or family who we care about. We have to aim for doing the best that we can. And constantly improving.

The revised 2012 National Strategy for Suicide Prevention includes goals 8 and 9 which are specific to health care. Health care is a focus of suicide prevention is left out of the first national strategy in 2002 which seems remarkable but the assumption was that health care was ready and sufficient to work with people at risk for suicide and that we really had to focus on a more public health based approach around improving suicide care in other settings. Both are true. Suicide prevention has to be a public health initiative but also a mental health initiative. It was clear when the new national strategy was written as the task force was thinking about it that what was necessary to save lives is a better trained better prepared clinical workforce who uses evidence-based practices that emerged over the last 10 or 15 years. Believe that suicide prevention is a core responsibility of their work. This doesn't happen by chance. Most psychiatrists, psychologists and social workers do not get suicide prevention training in school and -- they don't even know who dies by suicide unless they are getting phone calls or somebody missing an appointment. So Zero

Suicide focuses on error reduction and patient care through a robust comprehensive system wide bundled approach to suicide care. We continually new knowledge about suicide and rigorous and through these effort systems have been reduction in suicide and suicide behaviors upwards of 65 to 75% and we have done previous webinars and we will have some stories about some of these early leaders on the Zero Suicide website later this year.

Seven components make up the Zero Suicide model each of which has been shown individually. Each of these tools is evidence-based. But the research as I said before is relatively new and most providers don't even know that this research exists or use these specific resources. Zero Suicide is not a program or a manual or a curriculum or even a marketing slogan. We are not looking for you to post flyers in your health care systems that you are a Zero Suicide organization. It is meant to be a transformational thought that the leadership in your health care system really -- it is an internal goal. Something that internally you can continue to strive for. It is a culture shift in how health care systems view and manage patient safety. So more specifically the core Zero Suicide is the suicide care management plan. Suicide care it must be routinely delivered much like standard care that would be delivered for people with diabetes. We hope we have a health care provider who is well trained in this diagnosis or that medical issue but we do leave it to chance. We have incredible clinicians doing hard work. All patients should be screened using a standardized screener tool and at multiple points throughout their care. Screening leads to assessment and formulation of the risk. Not everyone at risk needs to be hospitalized. In fact, providers often over rely on hospitalization when patients talk of suicide and in some cases hospitalization can be beneficial and it is the right course of action. So I don't want to minimize that. All patients will be discharged and then the health care provider and system needs to be confident and prepared to take the client back in. We rely on hospitalization because it provider anxiety, more than opportunity for real change and real care for the patient while an inpatient. For those who are screened positive for suicide they should have a safety plan developed on the same day as they screen positive. So they have something to use immediately to deescalate when the symptoms emerge. Safety plan should be unique to each patient and develop collaboratively. An important component of the safety plan is ensuring that access to lethal means has been reduced. Or those with the -- whom the patient lives to ensure that access has been reduced and removed. These patients with high risk are placed on high risk pathway and they can be monitored closely by the system. They need to be given evidence-based treatments

that directly target their thoughts of suicide. And continuity of care has to happen so that we are ensuring accountability. Those who are on high risk come to appointments. It can't be a slip of paper and ask that they go but maybe educated about what the appointment entails and why they need to go and encourage to continue with their treatment. And the health care system should follow up to check that they went. All these practices should be embedded in the electronic health record and examine there is Fidelity to these expected practices. If you are doing what you say you are doing and how well and where opportunity for improvement exists that's how the transformation happens. At the foundation is training in each of the components that I just mentioned. Not assuming by introducing them that the workforce will know how to deliver the elements. It includes training in each of the different pieces of evidence-based care that I was just describing, training in the rationale for overall model. Why are we taking on a comprehensive approach to suicide care. What does Zero Suicide mean for me regardless of what my role and responsibility is. This is our website, zerosuicide.com. It includes an implementation toolkit for resources for getting started. We have a great listserv. I encourage you to sign up after today. We will have Q and A at the end of today's session and I hope you do have more questions and more conversation you want to have with your peers. Please ease the Zero Suicide listserv to do so.

I just want to briefly tell you where to find what we call the Zero Suicide workforce survey because all of our speakers will be talking about training of their workforce. They did use the zero suicide workforce survey that they found on website. It is free and your organization can use it to assess the self-perception of your staff. How do they feel regarding their comfort, their knowledge, interacting with patients at risk for suicide. In including down to specifics. What is their comfort, confidence around screening or treatment or support during care transitions. It can help in how you design and prioritize your training needs. You can request this survey on the Zero Suicide website where that gold circle exists. Will be given an independent link for your organization that your administrator would send out to your entire staff, whole workforce and once a survey is closed your workforce survey administrator receives a survey to download the individual results. There is a lot of information that's available for administering this survey on-website. On to today's webinar. After today's webinar we want participants to be able to describe how surveying staff can support system wide culture change, critical to patient safety and continuous quality improvement. We want staff readiness, why is this important.

Why do you need to understand the readiness of staff and providing suicide specific care. What does that mean na will change within the system and beginning to understand the Zero Suicide workforce. These are our tremendous speakers. They come with great experience and knowledge in the Zero Suicide framework and in using the workforce survey and really helping them to drive change in their systems. I will introduce each of them in turn but I really appreciate their willingness to participate in today's webinar. So first up we have Katerina Barton. She is the project director at St. Joseph health care. She may be our first international speaker. So we are thrilled that we are able to take Zero Suicide internationally and draw from the tremendous knowledge that exists even outside of the U.S. She have been leading Canada's first implementation of Zero Suicide since 2016. Katerina is also eval waiting the Zero Suicide program as a part of her doctoral studies. Katerina has a clinical background in pharmacy infomatics and now mental health. So I'm turning it over to you.

>> KATERINA BARTON: Thank you very much Julie. I am excited to be here from Canada. We are quite a large organization. So we have several different sites. I am the project director for mental health care and also for the Webster for forensic men kal health care. We have about 4,000 staff, 1200 physicians, quite a large group of patients here. So I will go ahead. So as Julie mentioned we started with Zero Suicide in 2016. We ran a pilot with our adult ambulatory and concurrent disorder services. This is about 1300 patients and about 50 staff all together. That's where we first started with the workforce survey and since then we have been working on implementations in our in-patient units. We have several. And in our access teams and other ambulatory services as well. So what we did with our workforce survey was have specific surveys for different groups. So we had a survey for our clinicians in each program and a survey for our physicians. This is so that we can understand their different training needs. So the survey is good at helping us identify what training they are seeking, what their level of confidential and competence and comfort is in discussing suicide. We are glad that we separated them. We would leave our surveys open for two weeks and then provides tons of communication about this. Before we started the survey we would send a letter from our project sponsors or senior leadership, that's our VP and site chief physician. So they could understand that is coming from the top than was in -- it was an important initiative. During the survey while it was open I would send reminders via e-mail and we would talk to them in person. And right near the end of the survey would send a final reminder and a push from the leaders, like coordinators

and directors.

We are lucky enough to have on Zero Suicide team a clinical lead who has 28 years of experience in mental health nursing. She has been working with us for so long and knows everyone here. So she has been really a good asset for us in getting people to respond to the survey. So what she did she went right on to the unit and stepped in to clinical role so that staff could complete their survey and she would watch a patient so somebody could have ten minutes to do the survey and constantly providing reminders to staff regarding the importance of their responses. Letting them know that we are listening and we would follow up on it. She provided technical support when needed. There was some people that didn't even ever use their e-mail and we would send the survey by e-mail. So she could actually sit beside them and get them on their e-mail and signed in and then she was there also to remind them that there was full support from leadership in completing these surveys.

So our results varied between our different departments, different units. We did have some common elements. One was a feeling of not being supported following incident. So generally, you know, we do provide lots of supports here but we were a little bit surprised to hear from the stock perspective they were not aware of those supports and no formal processes in place. There was overall discomfort discussing suicide. There is a fear of triggering patients. Does that mean that we are going to trigger suicidality in them and there was a bit of a fear of professional consequences. Especially when the name zero has Julie mentioned. We are trying to discuss what that name means and why it was chosen.

So we used our results to inform our training plans. We had different training plans for each group in which we administered the survey. For our adult inpatient staff we had requests from them to learn more about risk factors, protective factors and even base can mental health status plans. Or even how to do them properly. We provided training on documentation, so they felt like they could document when, you know, assessment maybe didn't match what they felt the level of risk was and then tools and processing that we were implementing. They had asked for risk formulation the tools and processes as well. But they really wanted a methodology for managing suicidality. We provided them training on collaborative assessment or CAMS and that was through the camscare.com website.

So next what we do after a survey is finished myself and our clinical lead will analyze all the results. We focused on where people had answered strongly disagreed, disagree and even neutral to understand what areas of focus should be. We took it from general themes and we made recommendations to our steering

committee. We talked about different trends between the different groups and really tried to understand where our gaps with and what we should be doing especially with training. So we did have some unexpected results. We were surprised to hear in a mental health facility not many staff are comfortable talking about suicide. We have the best of the best here but even they were not comfortable. So we thought that was really interesting and something we should focus on. We also found there was overall lack of confidence in assessing and treating suicidal patients. Low understanding of organizational expectations when it came to suicide care. We did have -- we do have an organizational guideline for suicide care but not everyone knew about it and it just wasn't well-known. Something that surprised leadership especially. So to adjust the gaps we did develop these training plans. We provided basic training on mental status exams and also on proper documentation. Had to write a proper progress note. We had open discussions about the language of suicide. So we had a lot of feedback from patients and families saying that they would prefer to use certain language from the patient perspective. So things like saying died by suicide rather than committed suicide. We want to make sure we are providing clear communication of all the new processes, what sort of processes and tools we're eliminating. So after the survey what we did was we wanted to show the staff the results from the survey so they could understand what the results were for their overall area. We would tell them what the themes were that we pulled out. And then we talked about how we intended to apply those results to the training plan and overall changes in the organization. We do have a staff psychological health appear safety initial give going on and we connected with them to provide support after an initiative. Also make sure we make connections between our work and other ongoing projects. So there are lots of projects always going on in the hospital. We have one called vital culture, it is looking at culture shift on the inpatient unit and that was a perfect one for us to join on because we are trying to institute this blame free faith culture for staff.

So following up after we wanted to make sure that staff really understand that they have a voice in our initiative, especially this one. We are looking at the this no win culture and try -- as a huge undertaking for us. It is an ongoing piece of work for us. We are updating policies to support clinicians after there is a death by suicide. There is a review process that happens afterwards and we want to continue to encourage the patient first culture and we like to remind staff that's what we are here for and that's what we care about.

Okay. So when we did our pilot in the adult ambulatory

program what we did was used the survey right at the beginning before we did anything and then at the end of the pilot phase we repeated it for the same group of staff. And we compared our results and we had significant improvement in all of the areas of focus. So comfort, confidence, competence, all went way up from the beginning of the pilot to the end. And the further training needs they had expressed at the beginning all went down because we were able to provide the training they had asked for. We felt like this was a good measure of quality improvements and that we have been focusing just as much on our staff experience as on the patient's experience and we always try to make sure they understand that as well. So it helps us to connect the dots for staff. They would give us all the feedback all the time and we wanted to show them we made this change based on the piece of feedback you gave us.

So next steps for us we would like to continue with our kus on transitions and supporting staff and making that culture shift. We are also working on our sustainability plan for training, for compliance for all the tools and processes and having that ongoing communication plan. So we want to make sure that Zero Suicide is dynamic and every time there is feedback and we optimize based on feedback. We are looking for barriers to compliance and we want to know what's working well and what's not. Any feedback we get we take right to our steering committee and we revise any processes as needed. So I think that's all I have. So I would like to give it back to Julie. Thank you very much.

>> JULIE GOLDSTEIN GRUMET: Thank you so much Katerina. That was great. Just a tremendous opportunity to think about how do you actually use these results to make immediate change in your system. So what about the audience? Using the chat box, please tell us something you are going to take away from Katerina's presentation. Ah-ha moment, something that you hadn't thought of before and it relates to something that you are doing. Please type in something that you are taking away from Katerina's presentation that is going to stick with you today.

Great. Thank you. I was going to say taking a look at the chat, I can see the -- looks like multiple people are typing. We'll give you a moment. What is the key take away from Katerina's presentation.

I know for me that, you know, we keep seeing that people are not well prepared. That the workforce has far less training than we think that they do. So again I was saying we give our patients over to a clinical team that we expect to have this training but when we ask them about their comfort level they say I don't feel well prepared to do this. Several of you are

commenting that as well. Maybe in your own organizations you haven't had the chance to ask yet or made the same assumptions that all of us made. I want to encourage you to think how you can use that workforce survey, it is the same opportunity to kind of look in the mirror saying are we doing what we think we are doing. I see a couple of people commenting about language, using teaching staff, what is the right way to speak about suicide, made a suicide attempt that we certainly don't want people being described by their diagnosis, right? You don't -- you don't typically say she is depressed. We certainly to stigmatize people based on their diagnosis. We want to meet it head on something that we can treat and work with. Again several people commenting on died by versus committed. If you ask about suicide you might give people the thought or trigger them even more. What we learned from the research people feel very relieved. They are often not asked directly. The providers often expect that patients have a good relationship with them and will come in and tell them that they are thinking about suicide and yet they don't. I know one person who for many years was suicidal but also had a significant history of sexual abuse. She said her clinician thought he was doing a perfect job. She came to every single appointment and discussed that history of sexual abuse and when she made a suicide attempt ended up in the hospital he said he was shocked. She was seeing him for years. He thought he was providing him quality care. The other thing I see a lot of people talking about the importance of supporting the team after a suicide occurs and one of our previous webinars really focused on that. I hope you have a chance to take a look at that after today's webinar or continue the conversation on listserv. So we will continue with Q and A at the end but in the interest of time thank you for these comments. I' -- I will keep them going while introducing our next speaker and that way if you are beginning to have questions emerge or team can pull those questions. Or also I think obviously we all can keep learning from you. So I will let those go for another minute while I introduce Rob England. Rob is the health promotion manager not united Indian health services. Has 20 years of experience. Enhancing cultural knowledge and advocating for youth and families in the juvenile justice. He has been educated and done a lot of work laying the foundation for a great Zero Suicide program and including thinking about the workforce and the role that the workforce plays. So thank you Rob for being here today. And I'm going to turn it over to you as we change the screen. Thank you.

>> ROB ENGLAND: All right. Thanks Julie. The name of our project at United Indian Health Services is called Ko'l Ho Koom' Mo. Our organization participated in a Zero Suicide academy for

American Indian organizations one year ago. So here's a picture of one of our seven clinic sites Ottawa health village, Potawot. Due to size and location and the staffing available at each site. The distance between our northern and southern sites is about two and a half hours. While the distance between our northern site and most Eastern site is about three and a half hours. We cover an area approximately 5300 square miles which is just under the size of the state of Connecticut. The clinical services we offer include medical, behavioral health, dental, vision, and pharmacy while our community services includes programs and suicide prevention, tobacco and community health care programs of we have nine local tribes in our service area who make up a portion of our 11,000 active clients.

So our initial intent with the workforce survey was to find the staff and the organizational needs as determined by our own staff members. Many of line staff either have long established ties to our community and/or our members of local tribes. And as you go up the organizational chart, you will find that those that hold leadership positions do not have a long history of living in our area or being a tribal member. This survey allowed a safe space for the employee's voice to be heard and provides management the opportunity to listen to their staff. By gathering data from our own organization, it provides meaning beyond citing numbers from national statistics and also doesn't allow individuals to dismiss statistics by thinking they are different and this the numbers do not pertain to them. This survey allows organizations to be honest, with themselves and it is okay if we identify gaps in care as long as we committing to improving these systems moving forward.

By developing needed standard operating procedures and policies. So we collected our first workforce survey results in April of 2017. And this serves as our baseline data for our organization. We followed up with that effort with another workforce survey just last month. We felt that they were clear benefits to administering another survey, despite having valuable information from the survey last year that could have continued to guide our project. Before I get in to those details, one factor that we wanted to eliminate was a low response rate from our staff.

One recent experience we had from a fellow coworker helped dpluns our decision on the way that we wanted to collect our data. Our coworker utilized Survey Monkey and they were only about 15 people total who completed the survey and that survey was much simpler in design than the one that we wanted to have answers to. So we knew that we needed to take a different approach.

So we decided that we wanted to ensure a high response rate

with the survey and we wanted to include all employees. We wanted to get responses not only those from our clinical and community services, but everyone that was employed by our organization. We included employees who worked in executive offices, our fiscal department, facilities, literally everyone. We felt that the best way that we could survey all employees was to print out each of the surveys and have them complete the survey by hand.

And we knew it would be labor intensive inputting all our collected data by afterwards by choosing this method but we were willing to do this to ensure a high response rate and we targeted an all staff meeting. These all staff meetings which are ran by our CEO are meeting where all 7 sites come together and that only happens two times per year at our organization. We didn't request time on the meeting agenda just the opportunity to set up tables near registration where we directed employees to our area where we were set up. We knew that we wanted to give employees sufficient time to complete their survey. So we hand delivered surveys earlier in the day to every department around our immediate clinic. We offered incentives for those who completed our survey. And incentives given out included grocery tote bags, T-shirts from previous program events, rubber bracelets and some of the incentive items offered that you often see at tabling. We collected a great majority of our completed surveys in about 30 minutes. But it took the coordination of several staff members in distributing and collected completed surveys overseeing our incentive tables locating clips and pin boards but we do believe by starting earlier in the day it created a positive Word of mouth culture between the employees. The day prior to collecting our surveys we had notified all employees via e-mail with our intent and that we would be offering incentives for those that completed the survey. On the actual day that we collected surveys, another program for -- from our own division was attempting to gather data from employees and despite having a much simpler survey to complete, they received about half the number of completed surveys as we did. That program offered an handful of incentive items through a drawing while we offered an incentive item to each respondent. Let's say that we are believers in incentives to honor the time that people take completing the surveys and it makes it a bit easier to receive buy in from leadership when you say you would like to give their employees something. Something small. So one of the differences that we made with our survey this year in comparison to last, was that we went ahead and asked which county each UHS employee works in, and also what department and so we could separate that data and to see if there is truly differences in those areas. We also

made some revisions to more visibly identify the skip patterns in the survey as it was clear to us that employees had a hard time accurately following the appropriate skip patterns that would happen if you were completing the survey online. Our survey this year included stop signs and highlighted areas to help guide the respondents from answering questions that they were not required. We found those revisions and changes to be helpful, but still not necessarily fool proof. So earlier I mentioned how our organization had participated in a Zero Suicide academy one year ago. One of the challenges we faced is that three of the five people who attended the Zero Suicide academy are no longer at our organization. And this includes our CEO, our behavioral health director and a nurse manager. We felt it was important to gather the voices from our staff, once again to let the staff know that we are continuing on with this journey. Despite the changes in leadership and to inform new leadership of our efforts to address suicide at our clinics. One of the outcomes from our initial workforce survey was for more training and some of this was addressed by implementing QPR, question persuade refer training at new employee orientation. And we have been doing that since October of last year for all employees. We have also specified evidence-based treatment approaches for our behavioral health department in CAMS and DBT, calm and assist and we feel that our efforts in the last 16 months is reflected in our most recent results. We noticed a shift in these responses.

Overall I would say that many of the responses to the questions did not have that significant difference from our previous workforce survey. But we have seen a slight shift on nearly all of the questions. And so the bar appears to be moving in right direction in what we hope eventual culture shift. On the question of how do you receive training on how to recognize the warning signs that a patient may be at elevated risk for suicide, 68% of the respondents replied yes, in comparison to 50% from the previous year. When asked has your organization provided you with training on how to recognize warning signs, that a patient may be at elevated risk for suicide. 97% said yes, in comparison to 77% from the previous year and this question was tied in to the previous question for those that had said that they had received training. We also had an increased amount of staff members who had taken the counseling on access to lethal means course from just 3% to 17%. Although we would like to initiate an organizational campaign to increase this number in the coming year. Despite an increase in training since our last survey, we saw no difference in the responses to I am comfortable or confident in my ability to provide care to patients who have been identified at being at

elevated risk for suicide. So one of the areas of opportunity that has been very clear to us, is that we real ly need to have standard tools instruments or Rubrics beyond our basic patient health questionnaire screening. We have been having meetings to establish set standards for much of this year but the changes in leadership have slowed our progress and not having adequate time to have appropriate dialogue with our medical providers has been a challenge. It does appear that we are moving in the right direction at this time. And I would say at the beginning of this new year that those standards will be set in place. On a good note, more of our employees are becoming very familiar with the Zero Suicide initiative. And so we are happy to hear that. And as we move forward we are planning to highlight some of these key findings from our most recent survey results at our quarterly staff meetings that are hosted by our CEO. These meetings are held every three months in each of the counties that we serve. And we'll also dive deeper in to our findings and share the survey results at our organization's monthly zero sue so side team meetings as well. When we wait for these times when we are all together this will allow us the chance to have face to face interaction with staff members who may have additional questions or provide feedback that we need. In addition if we truly want to impact change on how we address suicide in our area, where the rate of suicide is double the national rate. It is important to share our organization's journey where we are addressing suicide with our own community partners and agencies. Hopefully we could serve as an example to other local agencies about the need to get started with implementing Zero Suicide and I will send it back to Julie at this time. So thank you.

>> JULIE GOLDSTEIN GRUMET: Thank you so much Rob. That was great. While we are changing the screen to go back and think about a key take-away from Rob's presentation I really appreciate Rob your honesty and transparency. In some areas there was change and some areas there doesn't look to be significant change. I think you highlighted so many of the things that health care systems do -- deal with, leadership does turn over and it is hard to destain the initiative when you are constantly just bringing people in at the ground floor. It sounds like you have been able to embed things through policies and trainings that are helping this to be really much more firmly cemented in your system. The idea that you had your staff take the tool twice, and look at planned post or look at it really throughout multiple points along the timeline is exactly what we want. It is both the tool to think about training and get some buy in from the staff that we want to focus our training efforts to make you feel more comfortable.

You might not have achieved that but having worked in systems I often wonder if the best trained, best clinicians will never say that they feel truly comfortable and confident and in some ways that humility is what makes going to some of the best health care providers great. We want them to have a sense of confidence and we want them to know that they have room to learn and improve. Thank you for a great presentation. I see a lot of people commenting already on some of the things that I said as well. That you were able to share. That your staff didn't improve their self-confidence and that's okay. Pleased to hear how honest your respondents were and enough to share very honestly. I think that that's such a great point. When we ask people seriously and honestly for their opinions and open that door people want to share. Patients want to share and ask questions direct. A couple of people commenting that the importance of recognizing staff needs and doing this regularly. I incentives seem to work for your system. It sounds like for you that was a really pivotal opportunity that that helped you to increase your workforce response. So I think that's great. It certainly key take away. Those of you not wanting to take on the workforce survey, these were some great sounds like relatively low cost incentives. And they like people like that you did this during meetings. So you have a set aside time when people already kind of are stepping away from perhaps other clinical duties and using that time to have people take the survey sounds like it also increased your results. And how personal it was in gathering information I see. And I see a few people saying they are going to really integrate in this their ongoing training. So thank you for the participants for sharing. I will leave the chat screen up. Continue to share your brilliance and thoughts and ideas while I am turning it over to Glenn. I will introduce him while we take kind of one more minute for people to write their thoughts. Glenn is up and we are thrilled to have him with us. Glenn Thomas is a clinical psychologist and director in behavioral health department at Nationwide Children's Hospital. He has been responsible for a broad range of evidence-based programs in the community. Past good behavior game and signs of suicide. Upstream approaches that we know reduce suicide in youth many years later. He is an adjunct clinical assistant professor in psychiatry and behavioral health. I love the diversity of our speakers. Having somebody from children's hospital, Zero Suicide is a fit for youth and adults and other settings. So I really appreciate the work that went in to with Nicole and others on the team thinking about the diversity in the presentations and the willingness of our presenters to join us. With that I'm going to turn it over to you.

>> GLENN THOMAS: Thank you, Julie. So I will start by talking a little bit about on continuum of care. We are a large behavioral health service line. We have roughly 600 staff. 500 of whom is a clinicians and we have a broad continuum of care. Part of the backdrop that I want to describe is our particular focus on evidence-based interventions over the last few years dealing with suicidality. We have a couple of dialectal behavioral therapy teams and we have rapidly increased our crisis presence in the community. We are now the walk in crisis center for children and families in our county. We have an outpatient crisis team that will respond to any of the hospital sites, including other behavioral health sites. And we have a youth crisis stabilization unit and our emergency department now has a behavioral health suite providing emergency psychiatric evaluations that is a continuous presence and has been around the clock and has been more almost two years now. The inpatient unit is about three years old. And as a result of the increase in our high acuity services and crisis we have a sort of corresponding increase in the inflow of high acuity patients to the rest of our continuum of care. And as you can see there really the only part of the continuum of care that we don't provide is residential placement. And this is part of the reason why Julie had mentioned our focus on prevention as one of the reasons we are going upstream, one of the things that we did a couple of years ago as well was create the center for suicide prevention and research which is a collaboration with our research institute and providing a lot of suicide prevention in the community. So in many ways we were primed for Zero Suicide because our entire continuum of care had become sensitized or increasingly sensitized to the needs of these patients and sometimes there was some concern expressed about the increasing acuity of these patients and we saw over 30,000 unique patients. A lot of kids and families coming through our service. So we did the Zero Suicide academy about 18 months ago. This was worth keeping our entire behavioral health leadership engaged, reviewing what we were about to do, then reviewing what we learned from the training. Our medical director then sent out an e-mail to all staff and we created a powerpoint where we trained leadership, not just on Zero Suicide but on the most recent statistics around suicide for our pediatric population in our area. And we have seen a roughly five fold increase in death by suicide over the last ten years in our immediate service area. There was -- and partly because of this I think we had so many requests to add representatives from all the areas across our service line that our implementation grew from 5 people to 19 including a person who had been a patient with lived experience.

And then these representatives were tasked with updating their respective areas. And once everyone had been trained across the service line, around Zero Suicide in a powerpoint that we provided to all of the leadership, we then sent out a detailed e-mail introducing the workforce survey and how to complete it. We have not had the ability to devote additional resources to Zero Suicide at this point. But there has been certainly a lot of enthusiasm about the initiative. So we in collaboration with the SPRC created nine different categories of people or areas in our service line to -- I'm sorry, I am not keeping up with the slides. So we created nine different categories that reflected we thought our service line in a way that conceptually made sense. We wanted to do this because we wanted to be able to easily find meaning in the results. And that we would be able to apply to what our relatively discrete areas within our continuum of care. Our response rate we have 480 responses out of about 600 people. So we surveyed clinicians and nonclinicians. So that's an 80% response rate which I think reflects the genuine interest in what we were trying to do and the increasing concerns about the acuity of our population. We expected that we would have certain groups that had very little exposure to patients with high risk. That would not feel confident and competent in providing care and that was particularly true for groups that see younger children. And also the psychologists who provide behavioral consultation on our medical units. So it certainly seemed that exposure to these sorts of patients drove confidence and competence and overall we were impressed with our results. At the same time while we clearly had areas of expertise, there were always a handful of people at least who strongly disagreed about -- disagreed or strongly disagreed about feeling competence, feeling confident, being aware of our protocol and procedures. And the other thing that surprises us was the number of clinician who had already been touched by a patient who had died by suicide. So we took those results and reviewed them with the implementation team which by now had grown to reflect every single area in our service line. The data were very clear about where our areas of need were particularly clearly defined. We already have a very well established initiative in our hospital called zero hero to eliminate preventible harm. We have a culture that over the last 10, 12 years changed has in terms of identifying risks and then preventing them from reaching harm wherever possible. We have a very well established reporting system and we have regular root cause analysis for when we have events and we reviewed the results within the implementation team. We then communicated them to all of the behavioral health leadership and then created

a powerpoint for the leadership of our various teams to then communicate and disseminate down to their various programs. We had already established monthly implementation team meetings but over the course of summer of 2017 we really experienced the loss of momentum and we addressed that by creating very clear tasks for the subcommittees that had been created to address the various elements of the Zero Suicide initiative. And we also then incorporated reporting out on our Zero Suicide outcomes in the form of QA reporting structure that we already have that goes up to our hospital senior leadership.

And so I think we are back on track. But for a moment there, we did lose a bit of steam. The -- sorry. I am just keeping up with the slides. So I want to talk a little bit about our next steps. Something such a large service line poses significant challenges and we decided we would use a step wise process in rolling out all of the Zero Suicide elements. Once we have a clear idea of numbers of youth or high acuity we would finalize our criteria to be on or off the suicide pathway. To prevent them from slipping through the cracks. So our screening pilots at a couple of different sites, we have over ten sites that we a behavioral health presence across the city, but we have started those screenings. We have metrics that we can easily measure using our electronic medical record to ensure that everyone should have had a screening had a screening administered and the screening then reviewed by a clinician. When a screening was positive that a risk assessment was then provided. And that a safety plan was completed. We intend going live with screening across the service line for all patients aged 8 and above the first quarter of 2019. We have updated the content of our risk assessment in our electronic medical record. And we will do the same with screening because we really want the EMR to support and drive clinical care so that we don't have to rely on the memory of and expertise of individual clinicians as much. Training is that for too long suicide prevention has depended on the heroic efforts of clinical and we are trying to build in to our electronic medical record tickler systems and semi structured protocols and structured protocols that ensure that we don't miss any child who needs a risk assessment or a screening.

And once we then have the solid numbers then we will roll out the suicide care pathway probably in the third quarter of next year and at some time during the second third quarter we plan on readministering our workforce survey. We are recipients of the one SAMSHA Garrett Lee Smith funds. They fund our transition of care intervention that we have just embarked upon. And we also have a relatively high number of trainings that are available at no or little cost that we have been able to utilize

for our clinicians such as CAMS training and AMSR and so on. So I think, you know, we have moved a little slower than would be ideal. But we are on track to really the end of 2019.

Thank you for listening to me. And I hand back over to Julie.

>> JULIE GOLDSTEIN GRUMET: Thank you so much Glenn. While I am moving to the chat and allowing people to kind of share their key take-aways, I will share a couple of mine. What you are describing embodies pieces of work for successful Zero Suicide agencies. It sounds like you made optimal suicide care. Zero Sue Syd is not this bolted on thing that sits out. It is a natural piece of the work with your zero hero kind of framework that the entire system is used to. So the more you can use the language that your system is used to and it doesn't feel sort of like a new initiative, rather like an initiatives that already successful that you just want to turn your attention to suicide care, think it is great. It sounds like you really use great quality improvement opportunities and sending it up to your leadership team and making your metrics visible. That allows you to both be really honest about slipping and traction but also being accountable and allowing others to take a peek. So I think that you are really exemplifying a really healthy and the journey that most health care systems take. I see one you our faculty talking about that this is a slow process and that is the reality. She is giving you -- I hope you saw it. She said don't get discouraged. She is a primary care physician in Michigan. Take it from her. Don't get discouraged.

A couple of people commenting that the concept of Zero Suicide being embedded is a part of the work that you do gives it kind of sustainability for the long run. Risk assessments, sounds like people are appreciative of doing risk assessments and how important they are as part of evidence-based mental health care. The EMR is the advancing your EMR being key and that's true. You absolutely can't do this work if this is not embedded in your electronic health record. We to have some system that use paper tools, that is possible. It is not impossible at all. But certainly having hard stops, Rob was talking about this even just in taking the workforce survey. Sometimes you had to be much more concrete for a very busy workforce showing them where to stop, where to start. So having as many pieces embedded and not relying on people using kind of tools that they have made up or -- realizing Zero Suicide is the best marriage. But supporting that with evidence-based tools.

I see a lot of people commenting on having the tool readily available and making sure your staff is comfortable with these tools. Talking about suicide as a part of every day practice. And why -- early on sometimes we see some providers begin to say

I have been doing this for 20 years. The research bears out that standardized risk tools do tend to be better. After awhile our own buy in creeps in. So it is really the intersection of both. So, you know, really again want to thank our speakers. I want to open this up for questions from -- to all of our presenters. So please use the chat box to share what questions you have for our presenters today.

I have seen a couple of questions begin to pop up. I'm going to try to move to one of those. One of the early questions was for Katerina. She was describing two different surveys. If I can make Chelsea or Nicole to make that box bigger. You described using two different surveys and Claire -- if you could just describe for a moment that different links for different departments and how use them. One of the things I wanted to clarify is I think Glenn was speaking about it the scale is 1 to 5 scale. The staff gets to rate themselves from strong tli disagree to strongly agree. Katerina can you say a little bit more how you sent the two surveys to your staff.

>> KATERINA BARTON: Sure. We did use the exact same survey for everyone. You go on and you request a survey link that's specific to whatever area you want to do. We separated about department and separate the clinician from the physicians.

>> JULIE GOLDSTEIN GRUMET: Thank you for the clarification. What do people think? I'll shoot this over to you maybe Rob to begin with. What kind of suggestions do you have to keep implementation momentum going desite staff turnover. I will start with you Rob. What have you done in the face of a lot of high staff turnover leadership turnover how do you keep this momentum going.

>> ROB ENGLAND: One of the things that has helped is having our QPR training at new employee orientation. So we onboard new staff members every two weeks and I think it is amazing on the first day and actually it is the first hour of hire is when they initiate that QPR training. And so I think that's just a good head start for all employees that begin at our organization and then, of course, there's other trainings that they can take, you know, throughout the course of the next year and as we start to implement Zero Suicide there are those staff members that able to participate in those meetings as well.

>> JULIE GOLDSTEIN GRUMET: Thanks. Katerina anything to add?

>> KATERINA BARTON: We have worked our training in to our orientation for our staff. As well as our other tools and processes.

>> JULIE GOLDSTEIN GRUMET: Great. Glenn, I think you have

given some feedback already. But anything else?

>> GLENN THOMAS: No, I think it does come down to how we train people to use our EMR and EMR is already supporting a thorough risk assessment and we will add the screening elements and other pieces in to it.

>> JULIE GOLDSTEIN GRUMET: I see a few people asking what is involved in risk assessment and I want to let people know there is a very strong implementation toolkit that is associated with zerosuicide.com and it walks through the evidence and gives some suggested next steps in each of those areas. So with regard to screening assessment, safety planning, training of staff each piece of that is within the toolkit. So for those of you looking to get started I really recommend a deep dive in to zerosuicide.com. I'm going to look towards you Glenn to begin with, whether or not you have any data regarding if you have been able to ling you your suicide events that you can relate to your staff training. Do you see any reduction, with the staff training that you can account for any changes in your suicide care and I would say sometimes you have to look at that as both proxy measures and long term suicide readmissions, patient satisfaction, coming to appointments.

>> GLENN THOMAS: So at this point we don't have the data to show that anything we have done has reduced readmissions. But we have only just begun tracking. And you know in spite of the fact that we have seen a significant increase in our county Franklin County here in central Ohio, that the actual base rate is still fairly low and I have -- so on average the last four years there have been four completed suicides, sorry ten completed suicides over the last four years in the age range 10 to 19. It is almost entirely those kids have not touched our system of care, particularly from a behavioral health perspective. So we will be looking at suicide attempts not as part of a large -- it is part of a larger effort that we are about to embark on, looking at data not in Franklin County but in our entire catchment area. And we want to be able to see if we can measure the move the needle in terms attempts as well as readmissions. I know we want to look at actual completed suicides but when you look at just nationwide children system of care, the change from the zero to one suicide from one year to the next doesn't really tell you anything about the standard of care we are providing.

>> JULIE GOLDSTEIN GRUMET: It is a low base rate. So it becomes really hard to see if this is impacting suicide. And, you know, and that's true sometimes. There are states that have many different types of activities going on and so we are looking for the needle to budge within the state but it is why we look at proxy measures. What's happening within each

individual patient. Are they having fewer readmissions. Are scores changing offer time. Are they following up on their appointments more. So, you know, I think there is still a lot to be learned about how assess the outcomes of this framework but I think, you know, we certainly are seeing that there are some early outcomes. Some of the systems who have been able to wrap their heads around a couple of year's worth of data will be posting those to the Zero Suicide website later this year. Because we are going to take you a little bit on their journey. How they -- what they found and how they looked at their data. So we'll put that on the Zero Suicide website when it is -- when it is ready for sharing.

>> GLENN THOMAS: Wonderful.

>> JULIE GOLDSTEIN GRUMET: Rob or Katerina, curious if you have any data you want to share. Any data about changes in your suicide events that you can say relate to your staff training?

>> ROB ENGLAND: I'll go ahead and join in on this. So at United Indian Health Services we haven't had a suicide between the last four to five years. But one of the things that I bring up to our leadership and medical department is that our measure cannot be death or by suicides alone. Because we are having a high percentage of our clients marking more than not at all on the ninth question on the PHQ9. And so then we also know that we have had tribal members die by suicide and they live in our community but they are not engaged with our services. So we have to find a way to reengage with our tribal members who are not actively using our health care system.

>> JULIE GOLDSTEIN GRUMET: Right and that is a challenge. What happens if they are not touching your system and think it speaks to, you know, Zero Suicide within your health care system means where are they coming in from and where are they coming out from. How can you think about ways to make that continuum of care stronger. Again easier said than done. But I do think, you know, data often reveals that these were not patients that necessarily touched your care but I don't think that that means that we throw our hands up. It means how do you get further upstream and how do you ensure that that the community around you knows that care is helpful. Sometimes I think that's it. If my experience has been some people with lived experience often feel like the care they received wasn't helpful. It is hard for them to come back. The idea that week tell a different story about hope and recovery and how care does target their symptoms and they feel better hopefully begins to impact that.

A few -- I see some other questions about what are some suggestions that you have for follow-up suicide prevention training within the workplace. After you have done your implementation of sort of your initial training, your initial

rollout what did any of you do six or 12 months later to reinforce this. Can anybody talk about their training package that they rolled out? Should we start with you Katerina? If you are on mute I can't hear you. While Katerina is thinking about it, Rob what about you? Are you able to speak some about kind of how you are training progression has taken place. Maybe what you did very quickly early on, what you did at kind of the six month interval and what you did maybe as boosters or what you held on to for later.

>> ROB ENGLAND: Yes, and so some of the trainings that we have offered is through our project is, you know, QPR training. And we have also seen more of our employees being released from our medical department to attend assist trainings than previously. And one of the things that has got me a lot more hopeful and being that we had that staff turnover that attended the Zero Suicide academy is that we brought in Dr. Ursula Whiteside for a one day training on meeting and beating the recommended standards of care for using the Zero Suicide approach with some DBT skills. And what I thought was wonderful about that training is that we had 25 employees at United Indian Health Services that were able to participate in addition to another 15, 16 from our community partners. And I felt like it was a training that allowed other people to understand what Zero Suicide is all about in a condensed time frame. And really reenergize and reinvigorated our system that went to that training.

>> JULIE GOLDSTEIN GRUMET: Thank you. She does a lot of great work. Part of what Dr. Whiteside has done is think about training -- how do you do some of the clinical components. How do you ask somebody about suicide and take that to a suicide assessment and then conduct a suicide safety plan because again I think the details are we can't just hand people the paper or insert it in to the HR and expect that our staff understand how to do a safety plan, for example. A safety plan in and of itself is an intervention. It really is meant to be very individualized and unique but most clinicians need training and understanding of the plan. It appeals back the assumption that people know how to do these specific pieces of care. It helps them dive in much more deeply. Katerina I think you were trying to speak a little earlier and we were not able to hear you. You were talking about your early on training and maybe what you saved for later because you can't do it all in the first month.

>> KATERINA BARTON: Can you hear me now? Perfect. So yeah, what we did is offer the training in bits and pieces but now that we figured out the general training we want to provide we are develop can an e-learning through our e-learning system hoping to push it to staff. We would like to push it as a

recertification every few years but we do offer for all mental health staff, including administrative staff we send them to assist training or applied suicide intervention skills training. So that's something that we are looking at recertifying as well potentially over time. So we are still working on our sustainable training plan but that's what we have in mind.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you. Somebody else is writing in about how do you get leadership buy in after of the initial rollout of the workforce survey or some of the training. And Glenn I think I'll start with you on this. You know, how do you get that leadership buy in. I would argue maybe it should happen before you roll out the workforce training. Workforce survey. But how do you get leadership buy in and in what way do you use the workforce survey and results to sustain that buy in?

>> GLENN THOMAS: I agree. I think that buy in is necessary before you roll out the workforce survey. And that's how we got such a high response rate of 80%. I -- it was actually very easy for us to engage leadership around the initiative partly because there were a number of leaders who went to the academy and with the blessing of our medical director and service line administrator and we have just seen the need increase so drastically within our system of care, that I think people are all too eager to use any tool that would be helpful.

There is a realization that while most of our staff feel supported when we have serious attempts or on the couple of occasions over the last couple of years that we have had death by suicide, that there is a lot of vicarious trauma on the part all the other staff who become increasingly anxious about their own case load. We are very quick to hear because we have services throughout our community when there is a death by suicide in a school or at one of the local college campuses. And I think just that a level of anxiety about how you manage high acuity patient and the impact to the family to the community we have done an lot of education about suicide Contagion with adolescents and young adults. It motivates people to want to provide better care because it is in everyone's best interest.

>> JULIE GOLDSTEIN GRUMET: Thank you. Rob any other suggestions? You have had to deal with new leaders. What did you do or how did you use the workforce survey to get buy in the face of -- and brand new leader who wasn't there when you guys got started?

>> ROB ENGLAND: Well, we are still in the process of hiring new leadership. We have an interim CEO and he has been there during our initial process. So I would just say that it

is just continuous work and being persistent and just trying to get the message out and utilizing our organizational newsletter, having that workforce survey. And just trying to be as present as we can be through all different avenues.

>> JULIE GOLDSTEIN GRUMET: And probably, you know, I think one of the things that and I heard just to add to that that I herd Glenn say was being transparent about results. So leaders want to know when they have embarked on an initiative how is this changing. Whether it is return on investment, staff comfort and confidence. Some of the hard data about outcomes. The idea of taking the workforce survey a couple of times and sharing that, but being really transparent about what this looks like in your system. I have experienced helped leaders and also the last thing that I haven't heard anybody mention is but having people on your staff talk about their experience of adopting a Zero Suicide framework. I think some -- maybe Glenn it was maybe you who talked about how many of your staff had been affected and had somebody die by suicide and you hadn't known that. So I think the more people talk about that and the more many cases we have staff on our teams who themselves are people with lived experience of themselves or their loved ones, even the leaders in our organizations I have been in many event where the leader stands up and says they themselves have dealt with this. It is an initiative that's grounded in the evidence base by driven by passion and heart. I think the more you can get people out in front to talk about kind of the impact this has been my experience this is -- this is what drives the initiative. I have time for one more question. I am going to go with this one. Anyone -- what do you do -- what's the plan for how you notify or discuss the staff when a suicide has occurred? I do know we did a webinar on post prevention but I am going to tie that back to training. When a suicide does occur in your system, how do you notify staff? How do you keep the motivation going? What kind of trainings do you do differently or how does it impact that? I'll start with you Katerina.

>> KATERINA BARTON: We do have a specific process. We do what is called a key step by the review. But here it is basically a review process where all the staff involved will get together and discuss with our privacy and risk team what happened, maybe they could have done or what they would do differently things like that. It is really a protected safe space for people to talk about it. So that's something we are looking at right now reviewing how that review is done. There has some perception from staff that it is almost like a blame session which is completely the opposite of what it is supposed to be. We are trying to work on just communicates that to staff

letting them know what it is about and that it is safe and it is a really important aspect of follow-up.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you. Glenn, have you dealt with this in your system? Have you had to do any sort of crisis intervention or training approaches as a result of suicide events in your system?

>> GLENN THOMAS: Yes. We have had a number of near misses. And we have -- most recently I think it was roughly two years ago maybe a little longer than that, if I remember correctly, that we had a death by suicide of an active patient. We try to handle this very sensitively. We are very fortunate in we have a very strong supervisory structure with a good ratio of supervisory staff to front line staff. I think that's one of the strengths of our system is that this is always someone to consult with when you have any concern about a patient and level of risk. We also have a review structure. We do not always include the clinician in those meetings because of the concern that they might be perceived as blaming. Which is have to be frank and honest. We do have a pretty active initiative called You Matter which is about siblings and staff wellness across the hospital and we have peer to peer support within behavioral health. I will say that our -- the clinician most recently affected I then asked her if she would be on our implementation team because of our concerns about blame, the trauma that the clinician experiences, and she has been a very active member and I think provides a valuable perspective. The follow-up training that we do is usually program specific. By and large I think the bulk of our workforce has had some kind of training around suicide, suicide assessment, most of them have had training in safety planning. We have not -- and our in our assessment of these tragedies there has not been a breakdown in terms of clinicians following protocol either. Certainly retraining is important. I think being sensitive and imperfect and trying to understand what the clinician is going through, ultimately is the most important thing and then wrapping the supports that we do have around that clinician.

>> JULIE GOLDSTEIN GRUMET: Thank you Glenn. I think -- I love that you said you don't want to traumatize the client -- the patient -- the clinician by making them feel blamed and yet you really not you about ways to bring a clinician who is experienced in to leading the initiative and I think that is just a great sort of continuous quality improvement and shows your staff how much you care about them and their opinion matters. I think that's training of your workforce. And now she will go out and be part of the Army and talking about the importance of this initiative and how cared she was by the team. Nice way of wrapping today up. I see so

many great comments in the chat and just want to thank all of today's participants for a very lively chat. Sorry we dent get to all of your questions. Look to zerosuicide.com. You can find information at zerosuicide@EDC.org. You can sign up for the listserv or e-mailing this address if you can't figure out how to sign up. And continue to post your questions. These are important questions. It is a tremendous community of people who share. They are not looking for you to reinvent the wheel. Look for their expertise and this is a great opportunity to be a part of. I want to thank our speakers for sharing their expertise and experiences. I want to thank our staff for putting together a webinar and it take a lot of work to put these together. We will have two more webinars coming up over the next year. Dates to be announced later typically over zerosuicide.com and SPRC. So stay tuned and thank you again. Everyone have a great evening.

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