ZERO SUICIDE DATA ELEMENTS WORKSHEET

Description and Instructions

This worksheet is intended to assist health and behavioral health care organizations to develop a data-driven, quality improvement approach to suicide care.

This worksheet:

- Reflects the top areas of measurement that health care organizations should strive for to maintain fidelity to a comprehensive suicide care model.
- Includes a list of supplemental measures that organizations may want to consider. These measures are clinically significant but may be more difficult to measure.

The Data Elements Worksheet should be completed on a regular schedule established by the organization, such as every three months, and a team should use the findings to determine areas for improvement. The data elements included on the worksheet can be captured in an electronic health record to allow data to be tracked and compared over time. Organizations could also use the Zero Suicide Data Dashboard to track and monitor the data that is included in this worksheet.

Zero Suicide is an evolving model. While each individual component of the model reflects best practices in care and treatment, we understand that variations will occur in delivery and setting. However, it is vital to measure organizational practices and patient outcomes and to begin to create a shared understanding of what it takes to reduce suicides for those enrolled in care.

Use the Zero Suicide Data Elements Worksheet in conjunction with the Zero Suicide Organizational Self-Study and your Zero Suicide Work Plan to determine where improvements can be made in care, training, and policies.

Terminology

Case closed: Cases are considered closed when a person has not had an appointment in six months and does not have an appointment scheduled in the future. To count suicide deaths for those enrolled in care, we suggest a rule that uses (1) the case closing date and (2) the time since the last kept appointment. Under such a rule, a suicide would not count if it occurred more than 30 days after a case was closed. But even if a case had been closed fewer than 30 days, or it was still open, the suicide would not be counted if it had been more than 180 days since the last face-to-face contact and there were no pending appointments at the time of the event.

Enrolled in care: A patient enrolled in care is anyone with an open case file, who was admitted as a patient, or who has been seen at least once.

Open case file: A case is considered open at the point of intake or first contact, regardless of whether the person is formally admitted into care. It is assumed that the screening, assessment, safety plan, and lethal means discussions will take place at the time of this intake or soon thereafter. If the patient is not immediately admitted due to a delay in appointments with a psychiatrist or another similar barrier, the case is still considered an open case file as of the first contact.

Per 10,000 population: Statistics around the prevalence of conditions or risk are often shown as "per 10,000 people." For rate of suicide death, we recommend using the 'per 10,000 people' measure. For example, if 25 of the 4,500 people who were enrolled in your organization died from suicide in the last three months, the calculation is: 25 / 4,500 = .00555 * 10,000 = 55.5 per 10,000 people.

Risk assessment: A suicide risk assessment is typically performed after an individual scores as 'at risk' on a suicide screen. Suicide risk assessment usually refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

Safety plan development: Safety plans should be developed at the time of assessment when it is determined that a patient is at risk for suicide. While a safety plan may be updated and routinely monitored with the patient, only the initial safety plan should be counted in this metric.

Screening: Suicide prevention experts usually use the term suicide screening to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Screening tools are brief questionnaires that measure the individual's suicide risk. With regard to measuring screening rates, each patient is assumed to be screened only once. While this may not be the case in practice, do not count additional screenings on any patient in your total. Screening to determine that a person is at risk for suicide can occur during intake or at any point later in care.

Suicide attempt: Suicide attempts should be carefully and consistently defined by your organization and staff. For guidance on how to classify suicide behaviors, please see https://www.cdc.gov/violence-prevention/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/suicide/definitions.html.

Suicide care management plan: The suicide care management plan is an organization-wide care management plan, or pathway to care, that your organization develops to ensure that all individuals at risk for suicide receive timely, continuous, and effective suicide care services. An individual should be placed on a suicide care management plan as a result of being screened and assessed positive for suicide risk. Please see the Engage section of our online toolkit for more information about developing a suicide care management plan.

Today's date: _____

Reporting period (DD/MM/YY to DD/MM/YY): _____

Name of organization: _____

Name of person completing worksheet: _____

Recommended Measures:

	Measure	Numerator		Denominator		%
1	Screening	Number of encounters where a screening occurred during the reporting period		Number of encounters in which a suicide screen should have occurred during the reporting period		
2	Assessment	Number of assessments that occurred during the reporting period		Number of patients screening positive for suicide risk or being referred for suicide ideation or behavior via another mechanism during the reporting period		
3	Safety Plan Development	Number of patients with a safety plan developed (within the time period per policy/protocol) during the reporting period		Number of patients determined to be at elevated risk of suicide during the reporting period		
4	Lethal Means Counseling	Number of patients determined to be at elevated risk of suicide who received lethal means counseling (within the time period per policy/protocol) during the reporting period		Number of patients determined to be at elevated risk of suicide during the reporting period		

	Measure	Numerator		Denominator		%
5	Missed Appointment Follow-up	Number of missed appointments by patients determined to be at risk of suicide where follow-up contact was made according to organization protocol during the reporting period		Total number of missed appointments by patients determined to be at elevated risk of suicide during the reporting period		
6	Contact After Discharge	Number of patients determined to be at elevated risk at separation (i.e., discharge, referral, transfer) who were contacted after discharge during the reporting period		Number of patients determined to be at elevated risk at separation (i.e., discharge, referral, transfer) during the reporting period		
7	Caring Contacts	Number of patients that received a caring contact during the reporting period		Number of patients treated for suicidal thoughts and behaviors who separated from care during the reporting period		
8	Evidence-based, suicide-specific treatment	Number of patients on a care management plan that received evidence-based, suicide specific treatment during the reporting period		Number of patients on a care management plan during the reporting period		

	Measure	Numerator		Denominator			Rate
9	Rate of Deaths by Suicide Among ALL Patients	Number of patients who died by suicide during the reporting period		Number of patients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen		(Numerator/ Denominator) x 10,000	Per 10,000 population
10	Rate of Suicide Deaths Among Those with Identified Suicide Risk	Number of patients with a suicide care management plan who died by suicide during the reporting period		Number of patients with a suicide care management plan during the reporting period		(Numerator/ Denominator) x 10,000	Per 10,000 population

Supplemental Measures for Consideration:

	Measure	Numerator		Denominator		%
11	Emergency Department Usage	Number of patients who went to the emergency department for making a suicide attempt who had a suicide care management plan during the reporting period		Number of patients who had a suicide care management plan during the reporting period		
12	Inpatient Admissions	Number of patients who were admitted for an inpatient psychiatric stay for making a suicide attempt who had a suicide care management plan during the reporting period		Number of patients who had a suicide care management plan during the reporting period		

	Measure	Numerator		Denominator			Rate
13	Suicide Attempt Rate Among ALL Patients	Number of patients who made a suicide attempt during the reporting period		Number of patients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen		(Numerator/ Denominator) x 10,000	Per 10,000 population

14	Suicide Attempt Rate Among Those with Identified Risk	Number of patients with a suicide care management plan who made a suicide attempt during the reporting period		Number of patients with a suicide care management plan during the reporting period		(Numerator/ Denominator) x 10,000	Per 10,000 population