Welcome!

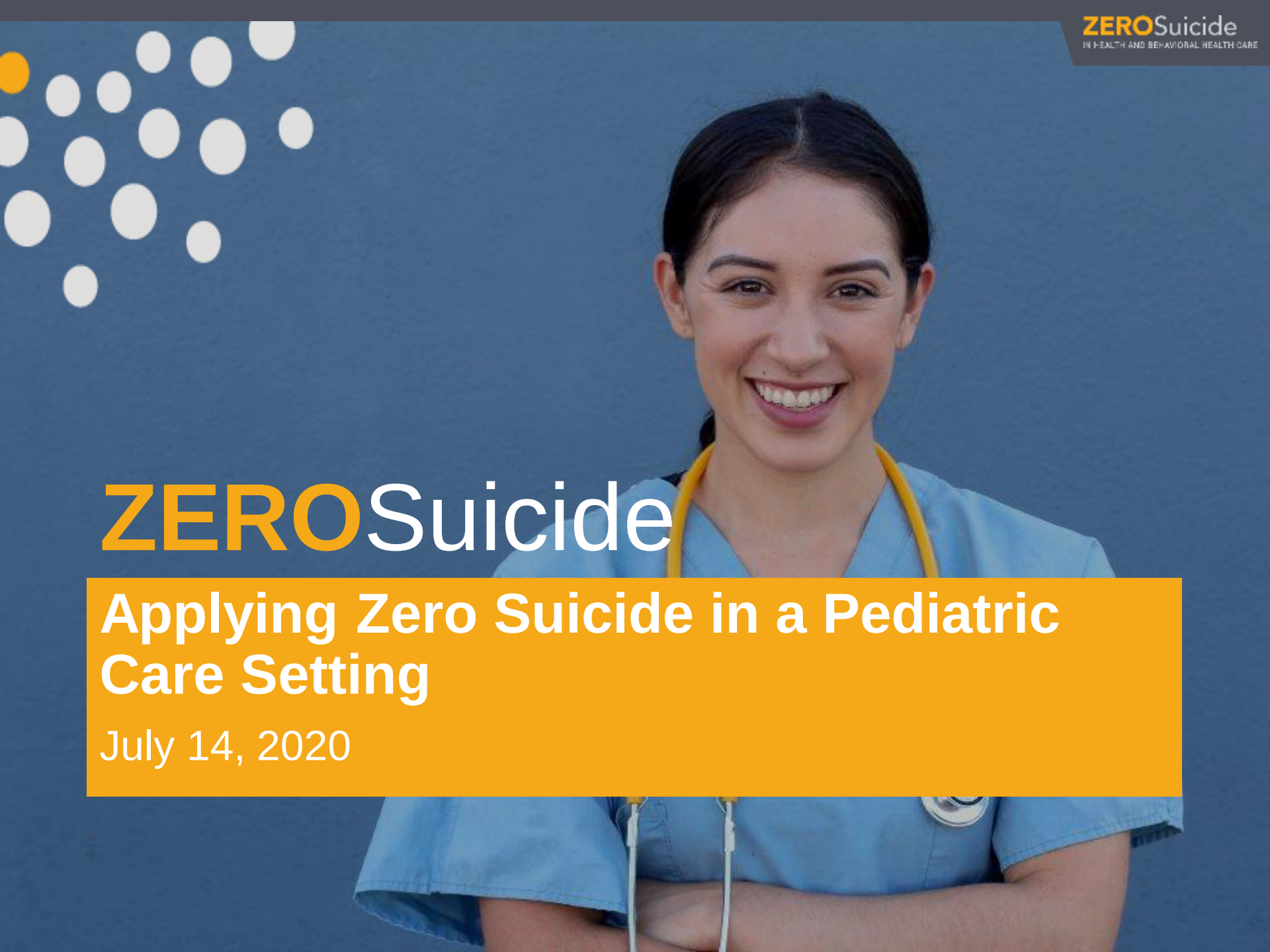
Let's introduce ourselves!

- Please type the following in the Q and A box:
  - name
  - organization
  - city/state

Technology Tips

Get Connected

- Technical problems? Call: **781-530-4708**.
- All phone lines will be muted for the duration of the webinar.
- Please type any questions or comments into the Q and A box.
- Click on the upper right to make the presentation larger.
- Click again to return to normal view.



ZEROSuicide

Applying Zero Suicide in a Pediatric Care Setting

July 14, 2020

Moderator

Julie Goldstein Grumet, PhD

Funding and Disclaimer

The Suicide Prevention Resource Center at EDC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 5U79SM062297.

Suicide Prevention Resource Center

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

The national **Suicide Prevention Resource Center (SPRC)** is your one-stop source for suicide prevention. We help you develop, deliver, and evaluate evidence-informed suicide prevention programs.

What we offer

- Best practice models
- Toolkits
- Online trainings
- Research summaries and more!

Who we serve

- Organizations
- Communities
- Agencies
- Systems

CONNECT WITH US

www.sprc.org

@SuicidePrevention ResourceCenter

@SPRCTweets

Zero Suicide

- Started in behavioral health—that's the core
- Aims to keep people alive so they can experience recovery
- Focuses on error reduction and safety in health care
- A set of best practices and tools including www.zerosuicide.com

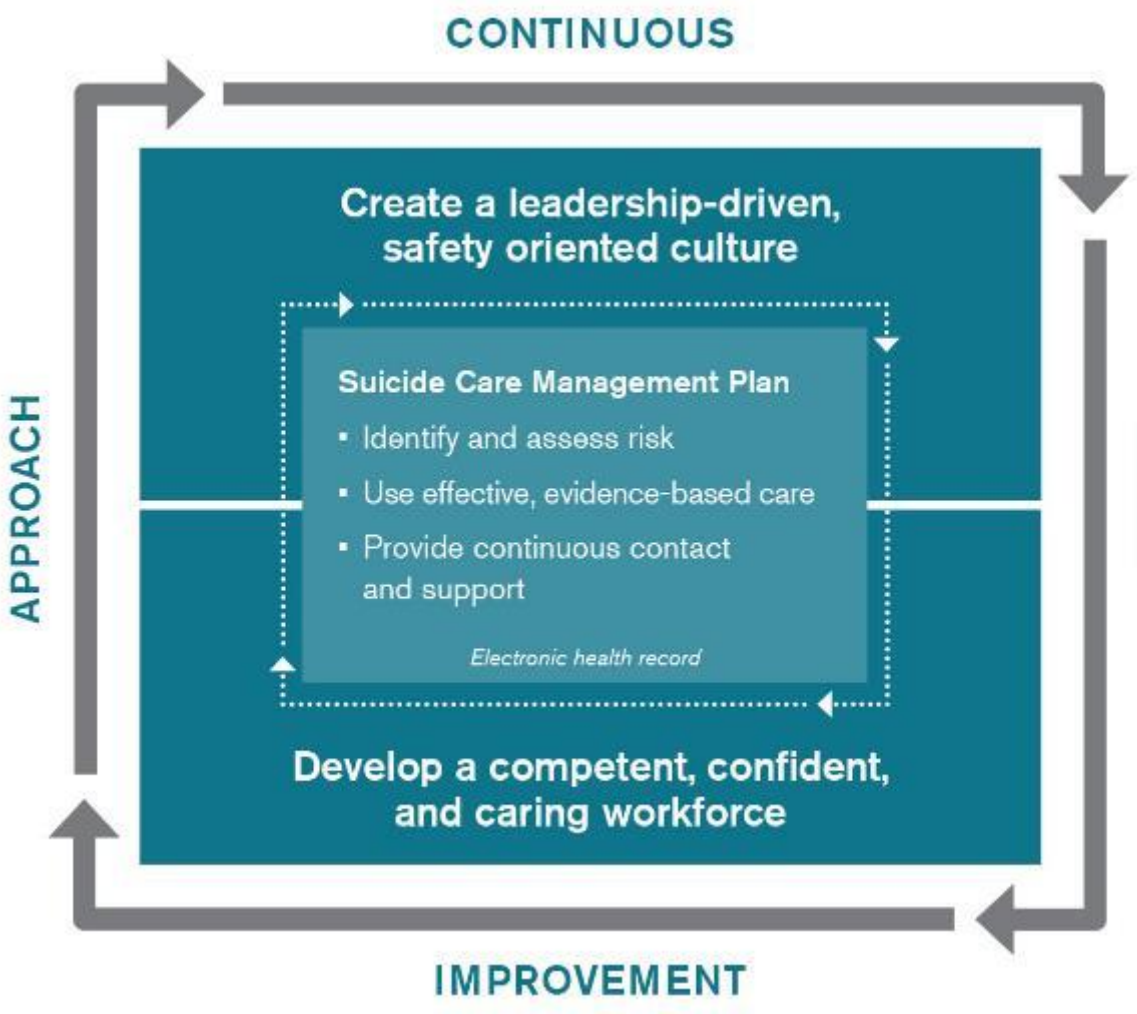
Seven Elements of Zero Suicide

www.zerosuicide.com

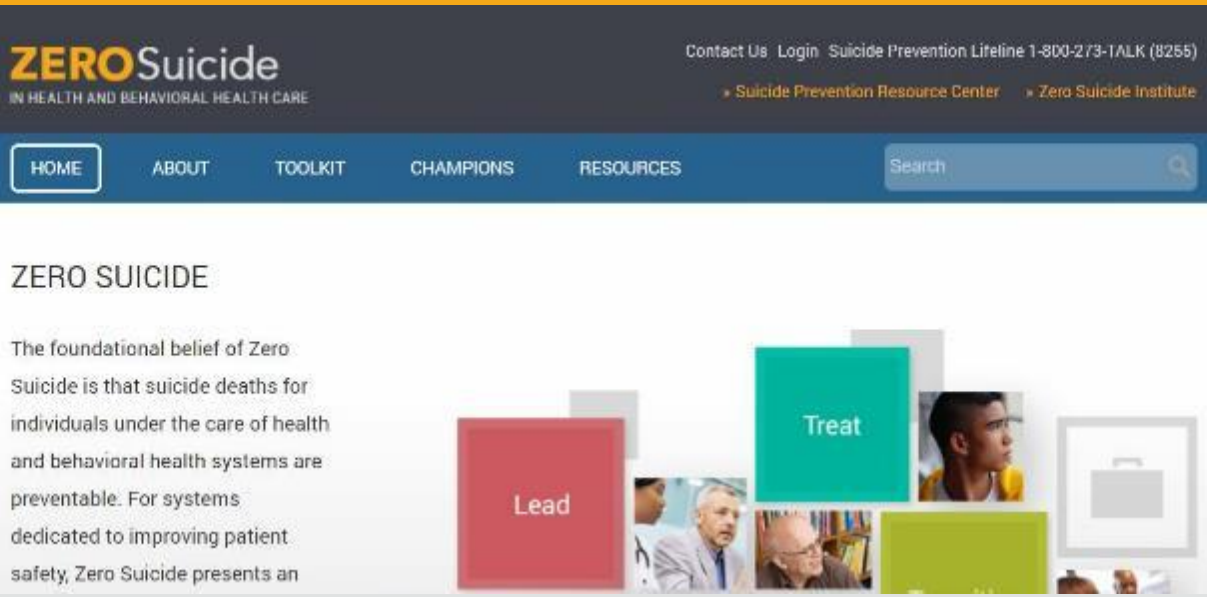
The National Action Alliance for Suicide Prevention outlined seven core components necessary to transform suicide prevention in health care systems:

LEAD	Lead system-wide culture change committed to reducing suicide.
TRAIN	Train a competent, confident, and caring workforce.
IDENTIFY	Identify individuals at-risk of suicide via comprehensive screening and assessment.
ENGAGE	Engage all individuals at-risk of suicide using a suicide care management plan.
TREAT	Treat suicidal thoughts and behaviors using evidence-based treatments.
TRANSITION	Transition individuals through care with warm hand-offs and supportive contacts.
IMPROVE	Improve policies and procedures through continuous quality improvement.

Continuous Quality Improvement



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 email list

Children & Youth Filtered Resources

IDENTIFY | IMPLEMENTATION TOOLS
ASQ Telehealth Youth Suicide Risk Screening Pathway

This suicide risk screening pathway from the National Institute for Mental Health's ASQ Suicide Risk...

ENGAGE | COMMUNITY RESOURCES
Seattle Children's Hospital Zero Suicide Initiative Pathways

The Seattle Children's Hospital created a Zero Suicide Initiative Pathway for use with children and youth presenting for care to allow for standardized processes for suicide risk screening...

IDENTIFY | IMPLEMENTATION TOOLS
Critical Crossroads: Pediatric Mental Health Care in the Emergency Department

U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau has released *Critical Crossroads: Pediatric Mental Health Care...*

LEAD | IMPLEMENTATION TOOLS
National AI/AN Hope for Life Day Toolkit

American Indian/Alaska Native (AI/AN) populations are at higher risk for suicide than other ethnic and racial groups, with youth and young adults being particularly at risk. Studies have found...

ENGAGE | COMMUNITY RESOURCES
Children's Hospital of Philadelphia Clinical Pathway for Youth

The Children's Hospital of Philadelphia (CHOP) created a Clinical Pathway for Children and Adolescents At Risk for Suicide in Outpatient Behavioral Health Care as a guide for staff on how to...

Learning Objectives

- Design adaptations to risk identification, assessment, and care pathway development to address suicide in youth-serving health care systems.
- Describe how the caring contacts intervention can be applied in pediatric settings.
- Discuss the importance of leadership and staff training to sustain practice change in pediatric hospital systems.

Presenters

Glenn Thomas, PhD

John Ackerman, PhD

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

Behavioral Health at NCH

- Largest Behavioral Health (BH) department at any children's hospital in the nation
- Over 600 providers across disciplines
- Broad continuum of services from prevention to inpatient, including Crisis services
- Increasing acuity over past decade
- Over 36,000 unique patients in 2019
- Over 255,000 outpatient visits in 2019

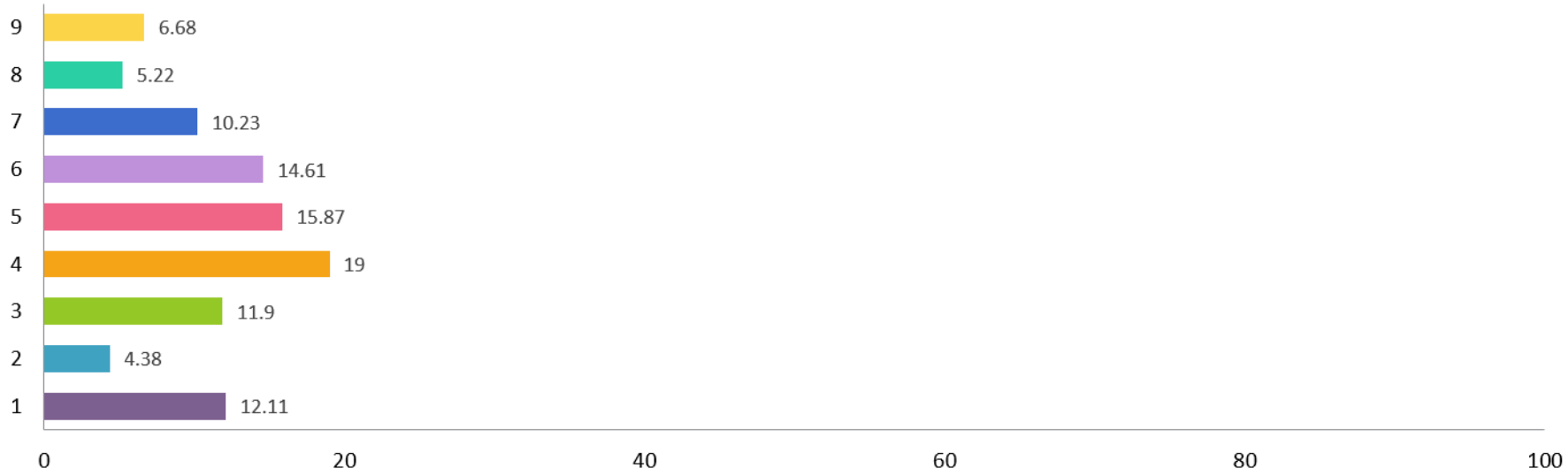
NCH and Zero Hero

- Quality Improvement embedded into culture
- Successful Zero Hero initiative started 12 years ago
- Focus on elimination of preventable harm to patients
- Expansion to preventable harm for staff
- Consistent with Zero Suicide model

Zero Suicide Implementation

- Zero Suicide Organizational Self-Study 2017
- Zero Suicide Academy® 2017
- Implementation Team formed
- Introductory e-mail from BH Medical Director
- Education on Zero Suicide: from management down to individual team level
- Zero Suicide Workforce Survey
- 80% return rate: 480/600

Workforce Survey



Value	Percent	Count
Psychiatry	12.11%	58
Intake	4.38%	21
Outpatient	11.90%	57
Community-based/intermediate	19.00%	91
Pediatric Psychology/CDC	15.87%	76
CASD	14.61%	70
Crisis/inpatient	10.23%	49
Operations	5.22%	25
Other Unit/Department	6.68%	32
	Total	479

Self Study and Workforce Survey Themes

- Areas of excellence
- Inconsistency across service line: confidence & competence
- Identification of high acuity patients
- Screening
- Assessment
- Clear pathway
- Continuing contact

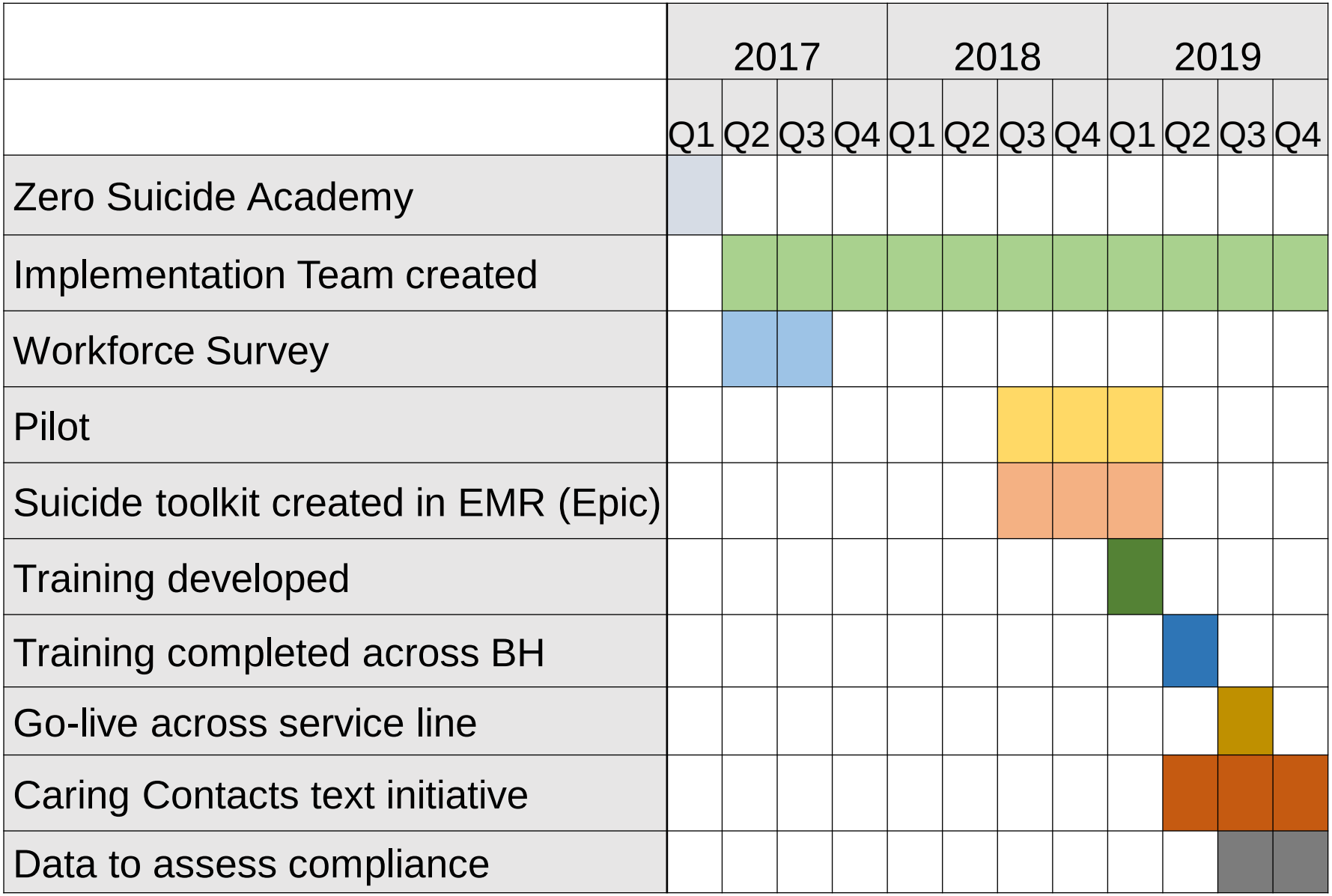
Dissemination of Results

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

Expanded Zero Suicide Implementation Team

- Initially proposed nine members
- Overwhelming enthusiasm → over 20
- All areas of BH represented
- Included lived experience
- QI representation
- Psychiatry
- Newly formed BH Education
  - EPIC/EMR

Zero Suicide Timeline



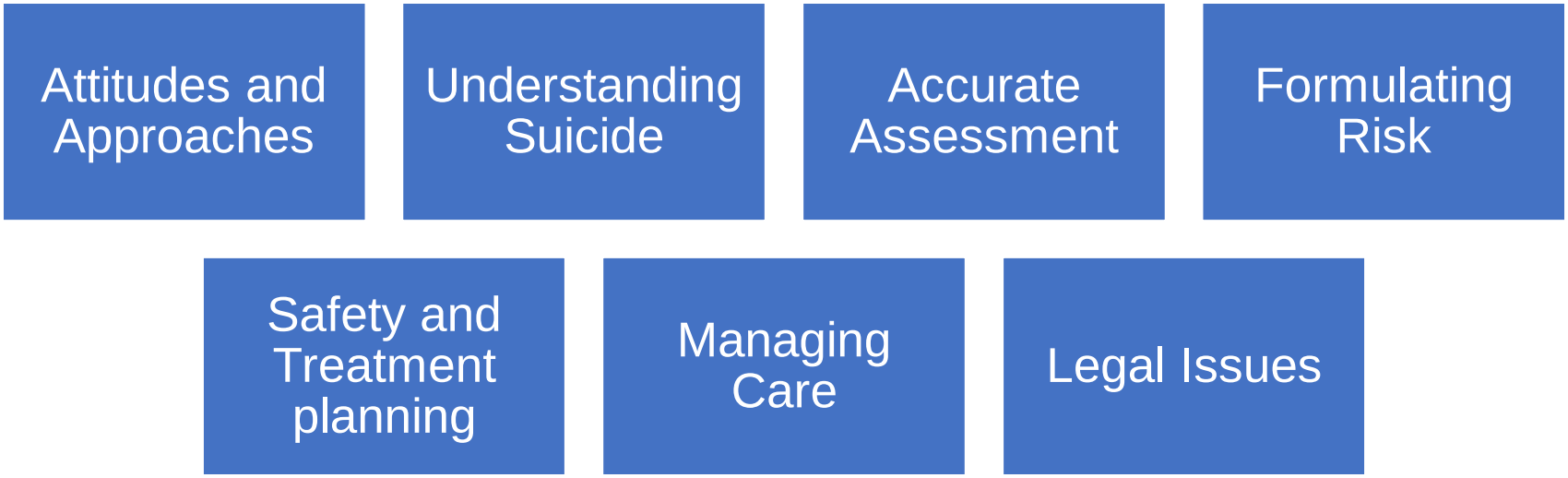
Training Approach

- Feedback from clinical leaders across BH:
  - Review aims of Zero Suicide and aspirational nature
  - Provide templates of workflows but allow for tailoring
  - Make sure EMR processes are automated to reduce decision-making burden (prompts/hard stops)
  - Eliminate duplicated effort
  - Focus on teaching standardized skills in screening, risk assessment, and safety planning
  - Ensure that managers can monitor compliance
  - Opportunities to discuss developmental concerns and team specific adaptations

Training Approach

- Clinical Coordinators trained in Zero Suicide framework and core suicide care competencies
- Piloting initiated with mood specialty teams, then large BH rollout, then medical specialties
- All BH clinicians & providers trained in two 3.5 hour modules
  - Screening process and ASQ
  - Risk assessment and the C-SSRS (very young child/cognitively impaired version)
  - Risk and protective factors
  - Collaborative safety planning (Brown & Stanley)
  - Suicide risk categorization

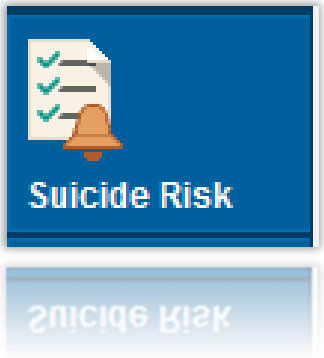
Core Competencies in Suicide Risk Assessment and Management



- Published by Suicide Prevention Resource Center [SPRC], 2006
- American Psychiatric Association Practice Guidelines, 2003

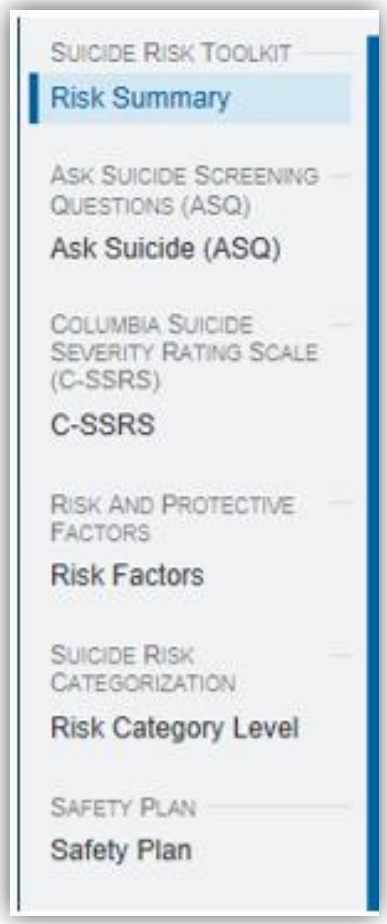
Allow Clinicians to Practice

- Training elements:
  - Review of clinical rationale and adaptations for use with youth
  - Review of specific items and preview of EPIC build
  - Trainer role play
  - Participant role play
  - Practice EPIC documentation

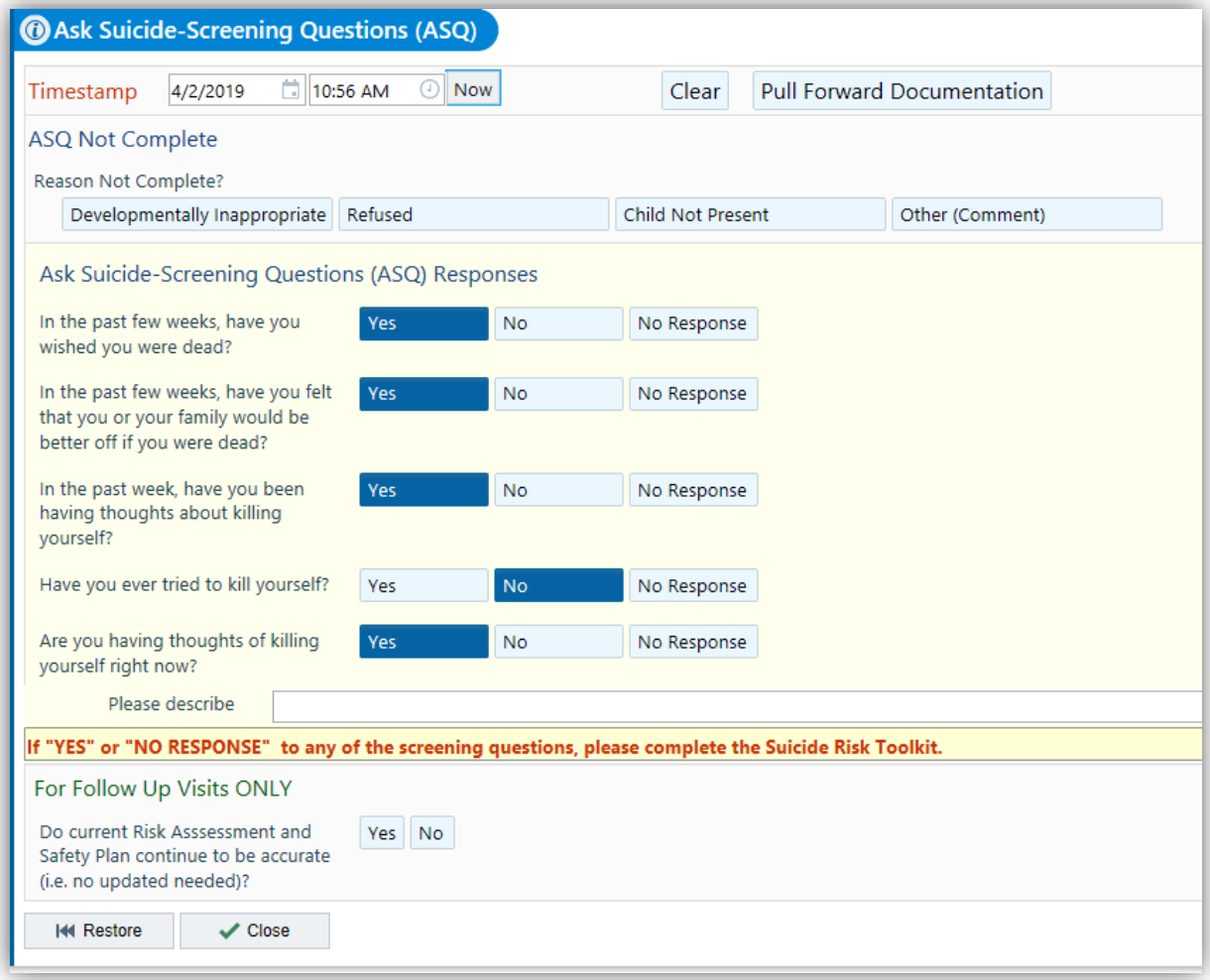


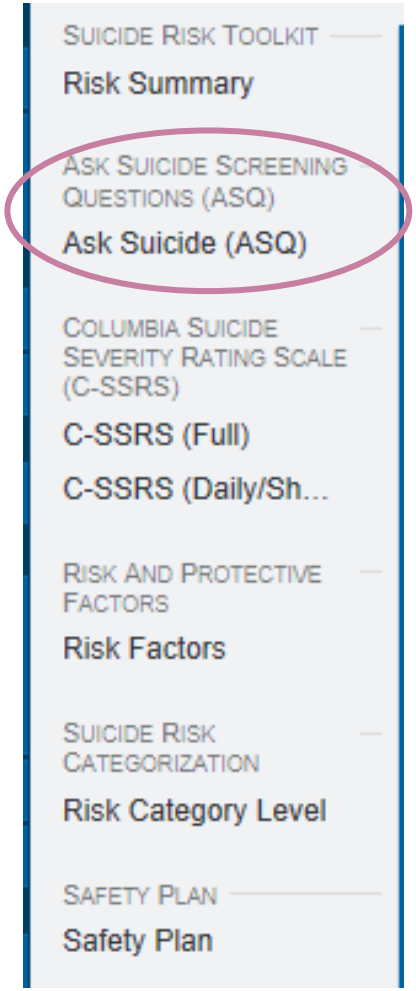
EPIC Suicide Risk Toolkit

- **Centralized way to access assessment tools across encounters**
- **"Toolkit" contains:**
  - Risk Summary
    - Previously documented values with date/time
      - Report to show trends in prior documentation
    - Banner when no documentation exists
    - Banner when documentation has been updated/exists
  - ASQ
  - C-SSRS
  - Risk Factors
  - Risk Categorization
  - Safety Plan, Safety Evaluation Education

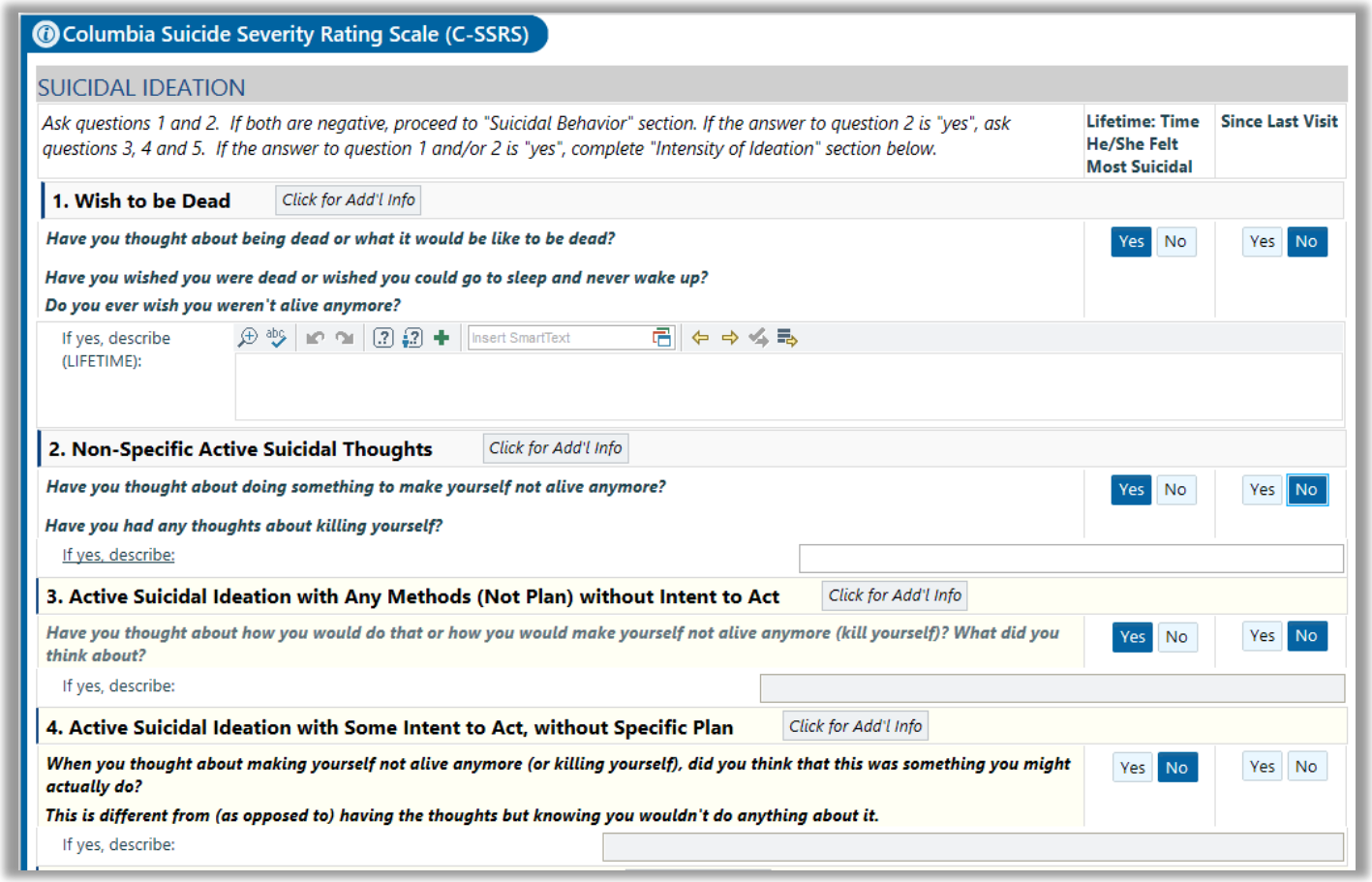


ASQ


Ask Suicide-Screening Questions (ASQ)
Timestamp
4/2/2019
10:56 AM
Now
Clear
Pull Forward Documentation
ASQ Not Complete
Reason Not Complete?
Developmentally Inappropriate
Refused
Child Not Present
Other (Comment)
Ask Suicide-Screening Questions (ASQ) Responses
In the past few weeks, have you wished you were dead?
Yes
No
No Response
In the past few weeks, have you felt that you or your family would be better off if you were dead?
Yes
No
No Response
In the past week, have you been having thoughts about killing yourself?
Yes
No
No Response
Have you ever tried to kill yourself?
Yes
No
No Response
Are you having thoughts of killing yourself right now?
Yes
No
No Response
Please describe
If "YES" or "NO RESPONSE" to any of the screening questions, please complete the Suicide Risk Toolkit.
For Follow Up Visits ONLY
Do current Risk Asssessment and Safety Plan continue to be accurate (i.e. no updated needed)?
Yes
No
Restore
Close


SUICIDE RISK TOOLKIT
Risk Summary
ASK SUICIDE SCREENING QUESTIONS (ASQ)
Ask Suicide (ASQ)
COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS)
C-SSRS (Full)
C-SSRS (Daily/Sh...
RISK AND PROTECTIVE FACTORS
Risk Factors
SUICIDE RISK CATEGORIZATION
Risk Category Level
SAFETY PLAN
Safety Plan

C-SSRS

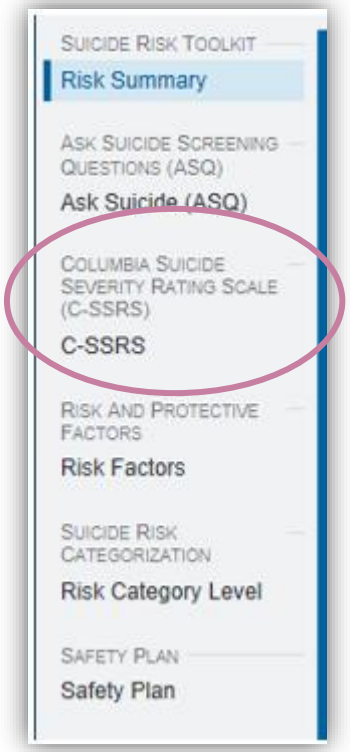


Columbia Suicide Severity Rating Scale (C-SSRS)

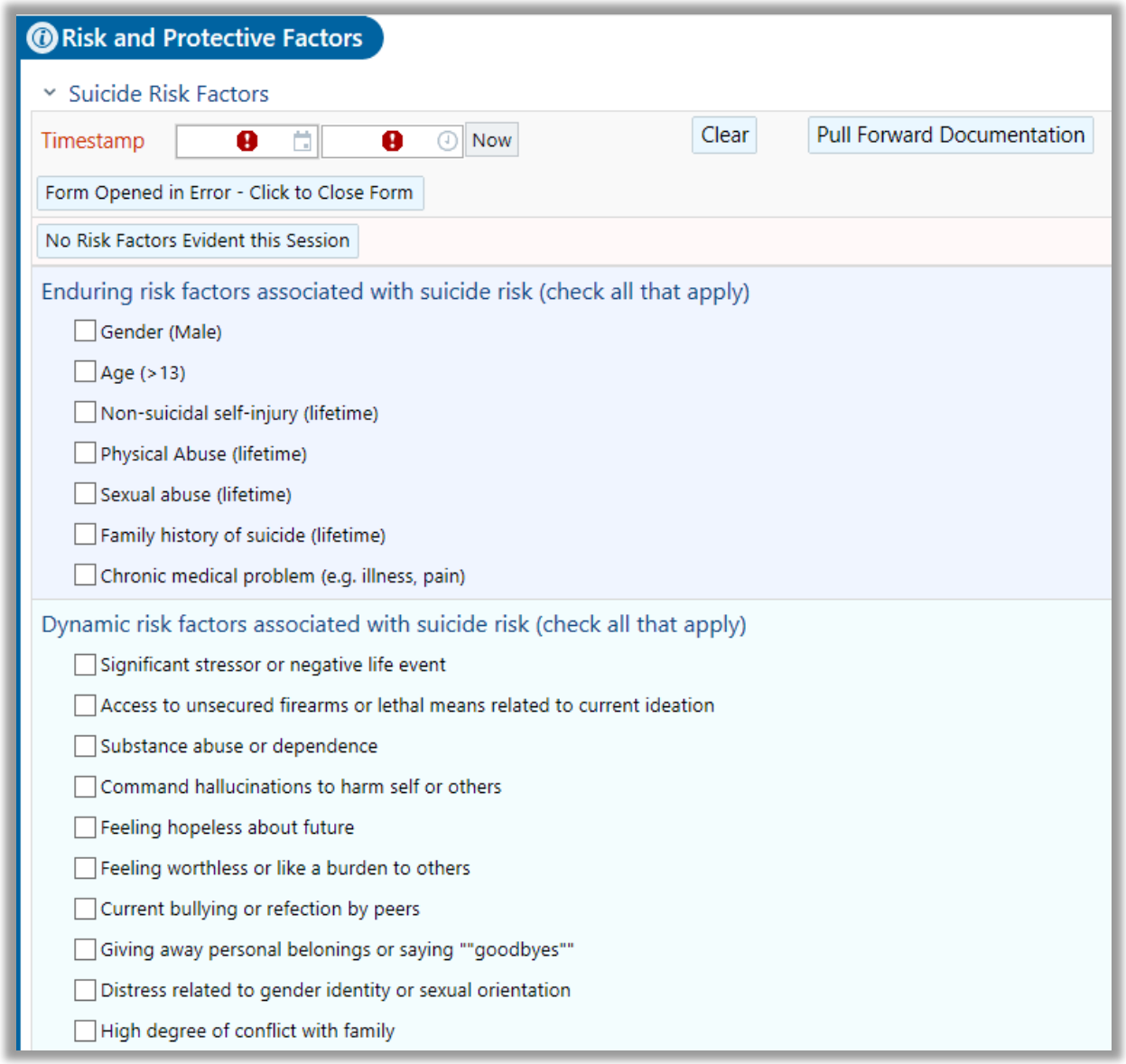
SUICIDAL IDEATION

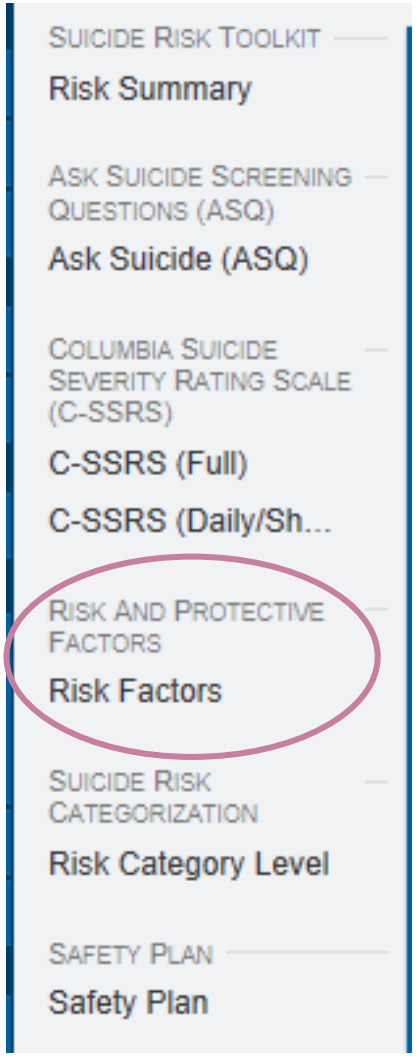
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Since Last Visit
1. Wish to be Dead *Click for Add'l Info*		
Have you thought about being dead or what it would be like to be dead?	Yes / No	Yes / No
Have you wished you were dead or wished you could go to sleep and never wake up?		
Do you ever wish you weren't alive anymore?		
If yes, describe (LIFETIME):		
2. Non-Specific Active Suicidal Thoughts *Click for Add'l Info*		
Have you thought about doing something to make yourself not alive anymore?	Yes / No	Yes / No
Have you had any thoughts about killing yourself?		
If yes, describe:		
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act *Click for Add'l Info*		
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?	Yes / No	Yes / No
If yes, describe:		
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan *Click for Add'l Info*		
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?	Yes / No	Yes / No
This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.		
If yes, describe:		



Risk Factors





Safety Planning

Ways to make the environment safe/limit your risk of self-harm:

How can we limit your access to lethal means/keep you safe during a crisis?

1.

2.

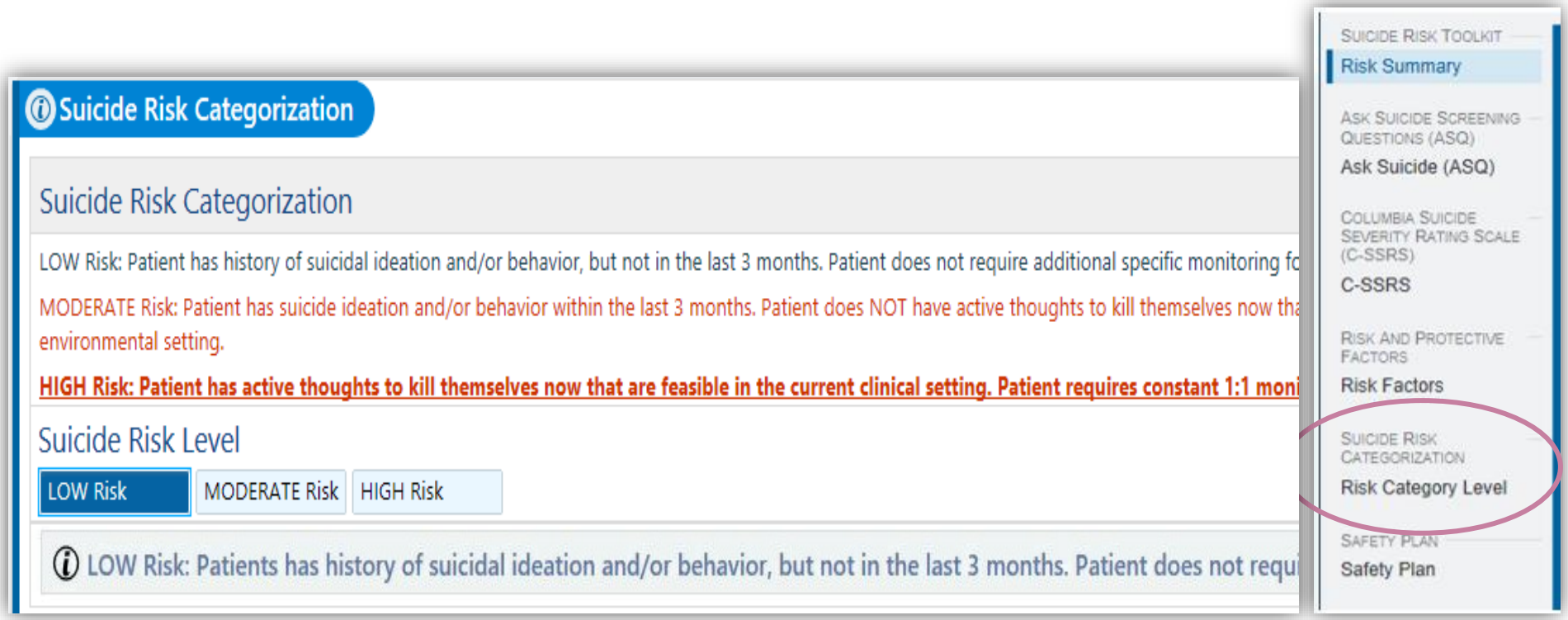
Ways to keep yourself safe during a crisis AT SCHOOL:

3.

4.

Collaboratively agree to safety precautions. Put systems in place to make safety plan effective. Engage support system. Consider code words, texting, regular check-ins. Role-play and rehearse.

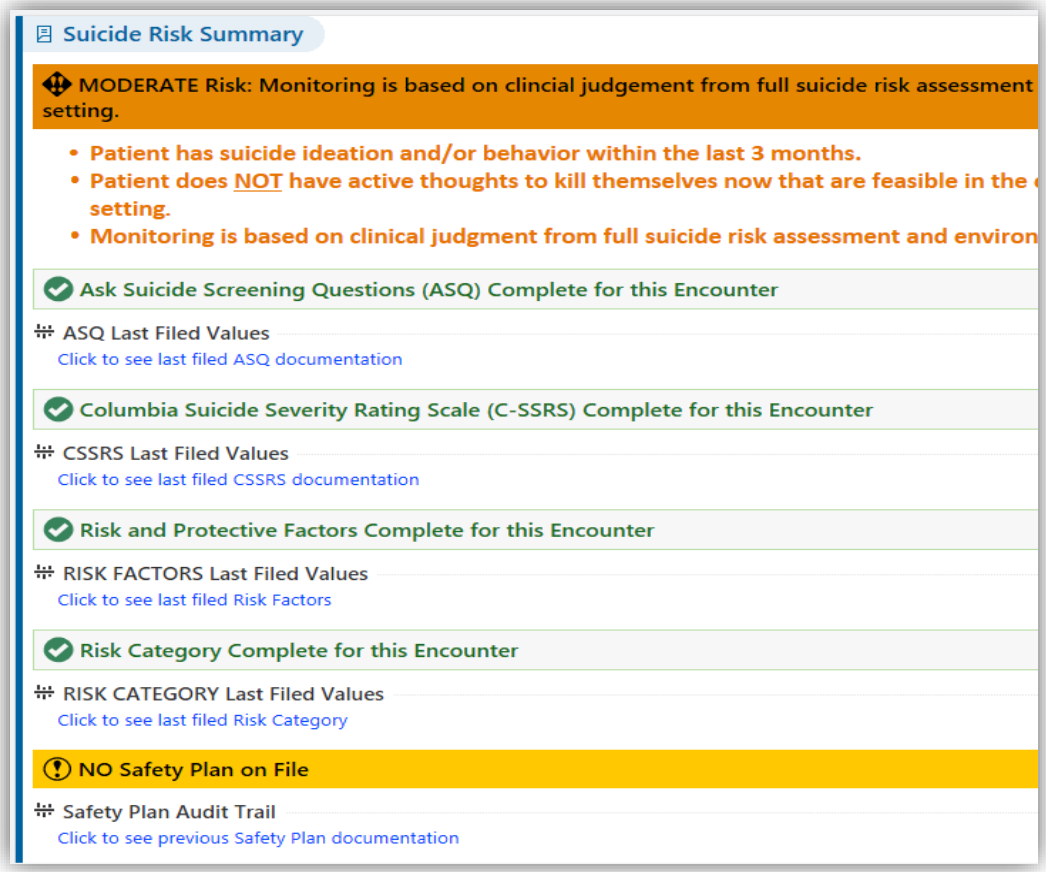
Suicide Risk Category



Suicide Risk Summary

Suicide Risk Summary Landing Page

- Quick viewing area to see the status of each assessment
- Last Filed Value Reports
  - Links to last filed values



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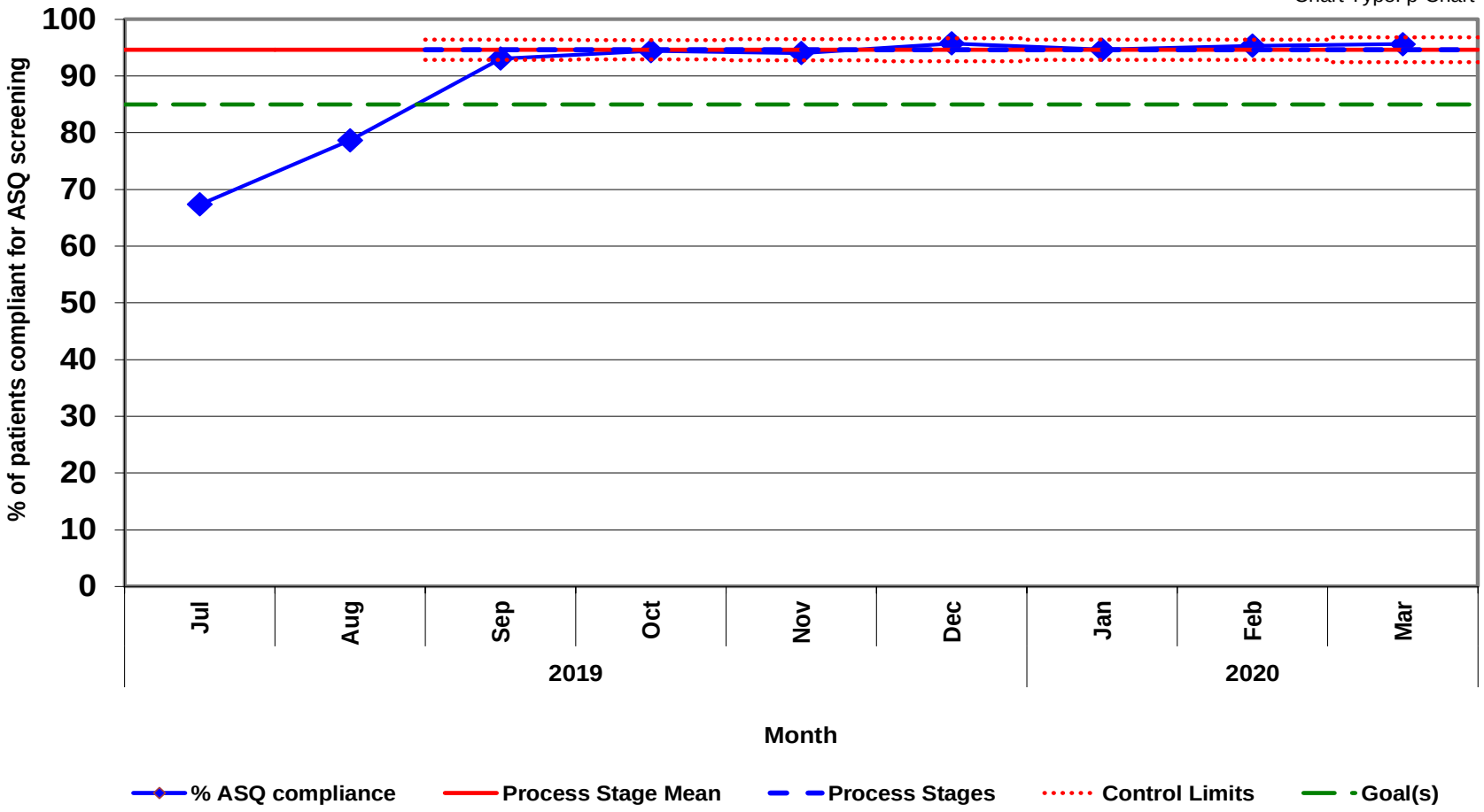
ASQ Compliance - BH Division (New patients and ED patients)

Desired Direction

Chart Type: p-Chart



ASQ	774	934	1301	1469	1235	1102	1347	1327	919
Patients	1149	1187	1398	1556	1313	1151	1423	1392	961

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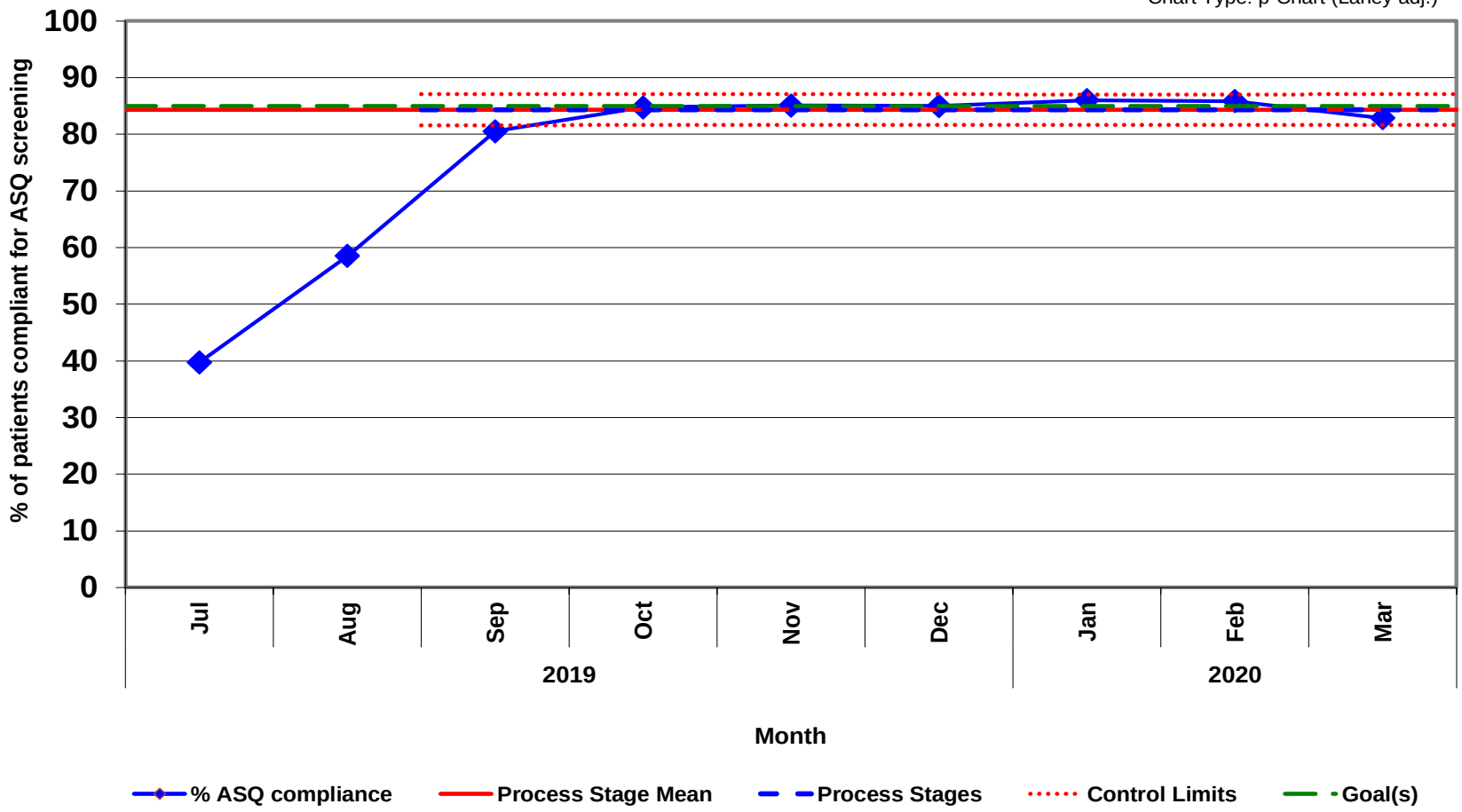
ASQ Compliance - BH Division (Follow Up)

Desired Direction

Chart Type: p-Chart (Laney adj.)**



**Alternative control limit calculations have been used to compensate for overdispersion (more variation than predicted) in the data of one or more process stages.

ASQ	1818	2633	3474	3981	3869	3877	4163	4106	3838
Patients	4576	4499	4313	4698	4547	4562	4839	4782	4632

Nationwide Children's
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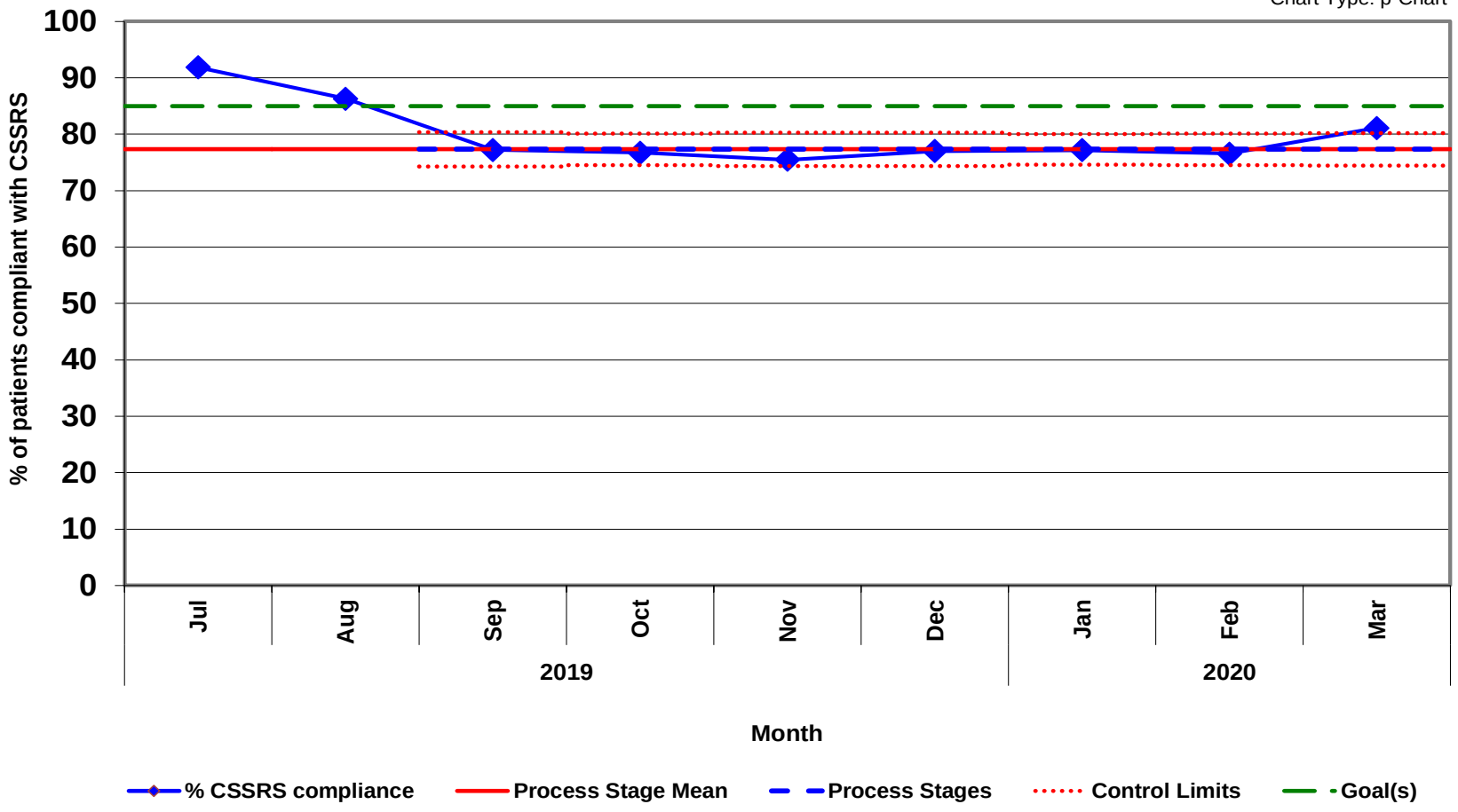
CSSRS Compliance - BH Division
(Positive ASQ's in all New patients, follow-up and ED patients)

Desired Direction

Chart Type: p-Chart



CSSRS	811	937	1300	1536	1346	1371	1632	1565	1541
Patients	883	1086	1684	2002	1783	1780	2115	2044	1900

Nationwide Children's
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Safety Plan Compliance - BH Division
(Postive ASQ's in all New patients, follow-up and ED patients)

Desired Direction

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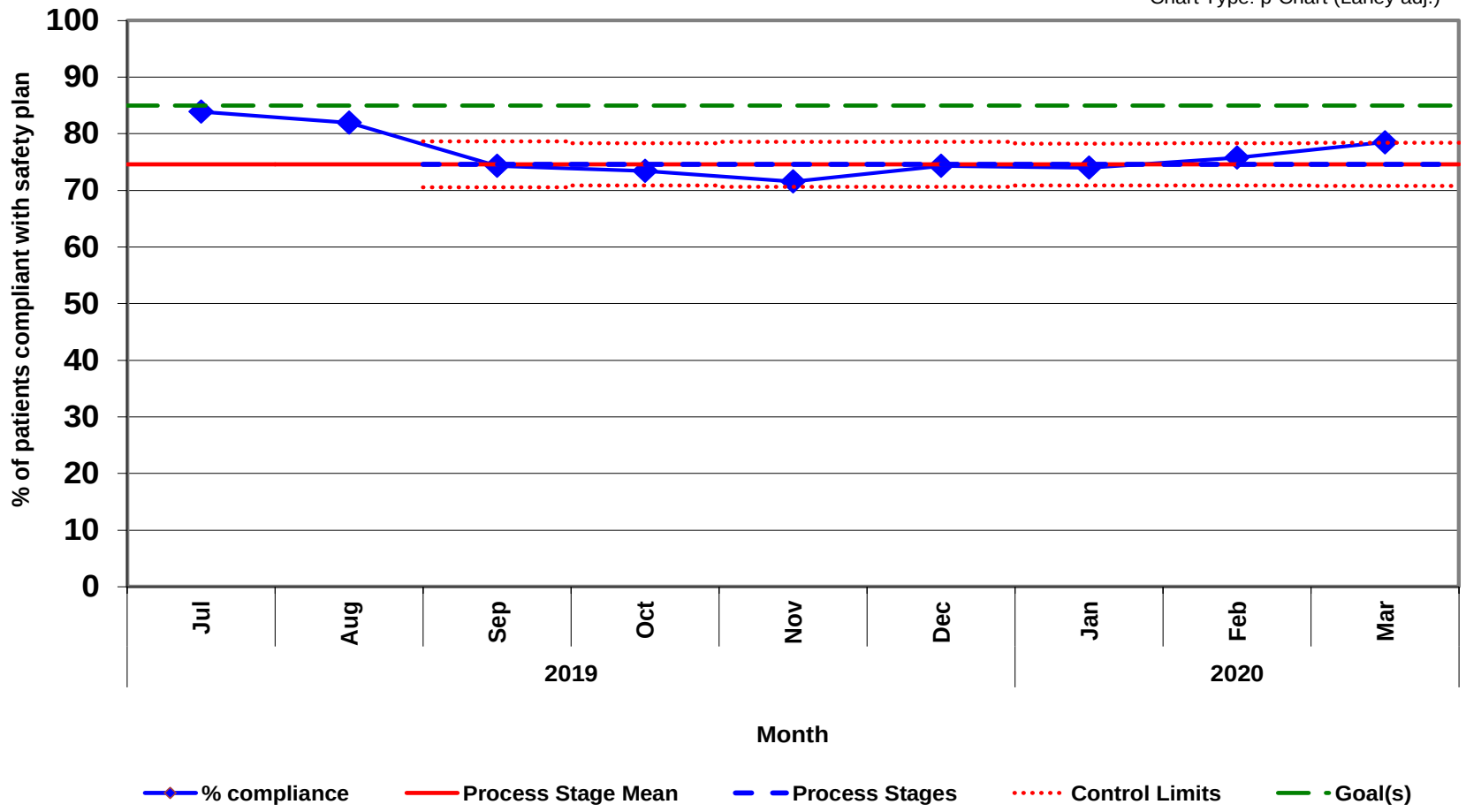


**Alternative control limit calculations have been used to compensate for overdispersion (more variation than predicted) in the data of one or more process stages.

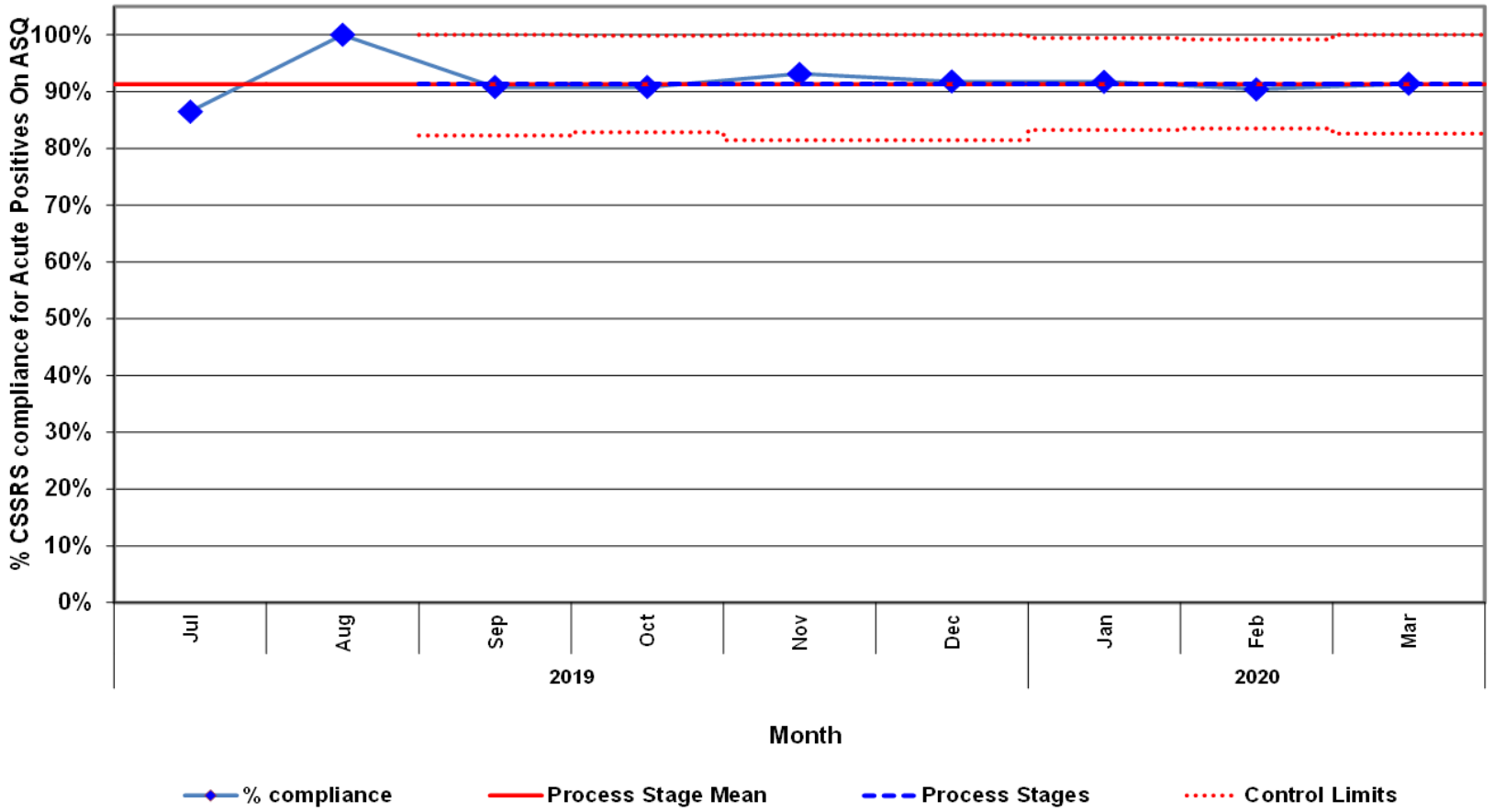
plans	741	890	1252	1470	1276	1323	1565	1549	1492
Patients	883	1086	1684	2002	1783	1780	2115	2044	1900

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

CSSRS compliance for Acute Positives On ASQ

Desired Direction

Chart Type: p-Chart



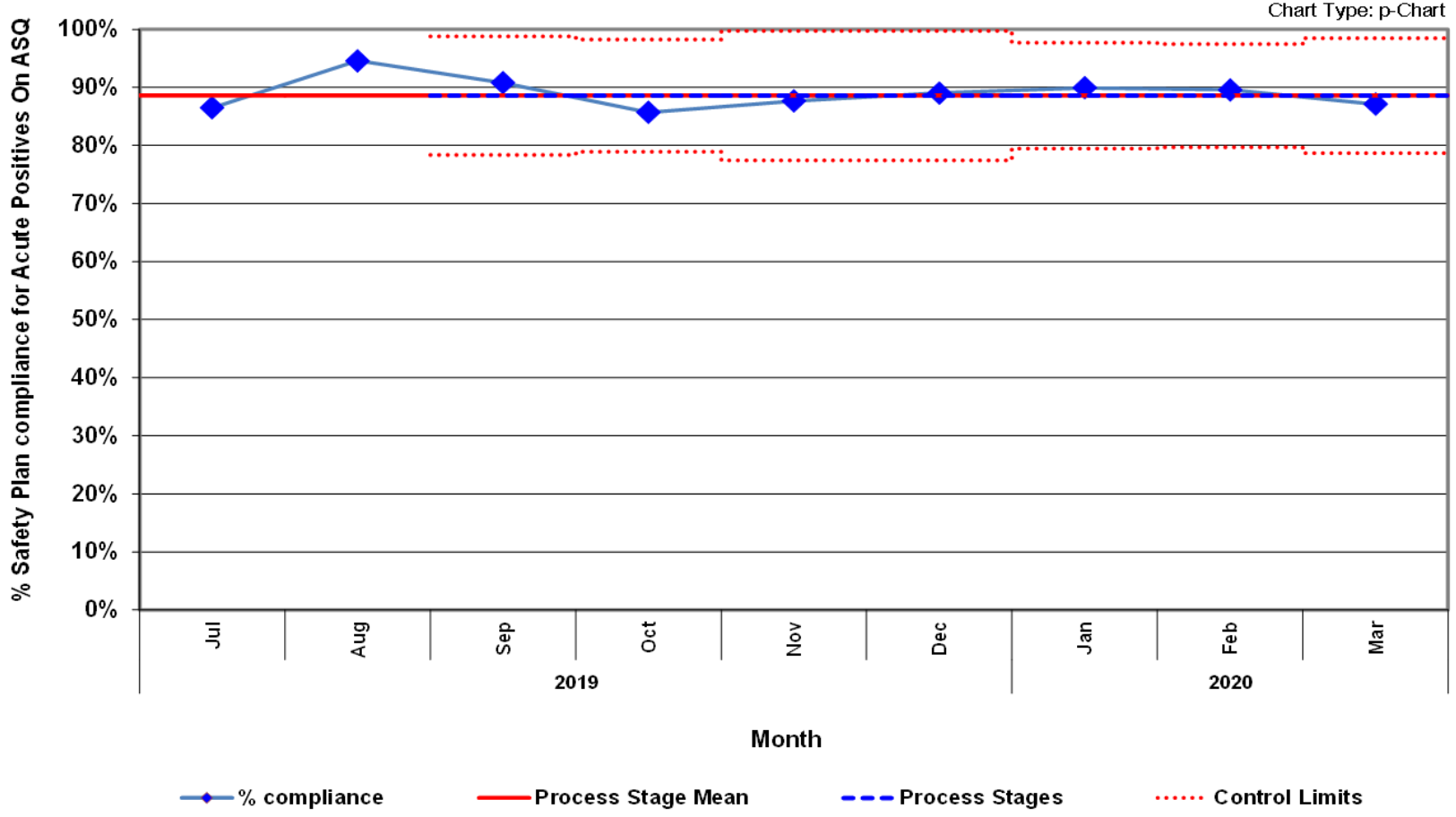
plans	32	37	79	89	68	67	100	104	85
patients	37	37	87	98	73	73	109	115	93

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

Safety Plan Compliance for Acute Positives On ASQ

Desired Direction

Chart Type: p-Chart



plans	32	35	79	84	64	65	98	103	81
patients	37	37	87	98	73	73	109	115	93

Caring Contacts

You can totally do this. Give yourself credit for how far you've come.

Background

» Nationwide Children's Hospital created a new standard of care as part of our larger Zero Suicide effort in 2018 (Transition element)

» Funded by the Ohio Suicide Prevention Foundation and SAMHSA GLS ("Ohio Campaign of Hope")

- *Caring Contacts* bridges the gap in care after a patient presenting with suicidal thoughts or behaviors is discharged from inpatient care or the emergency department

What is a Caring Contact?

- Inspired by letters that Dr. Jerome Motto received while he was serving in the U.S. Army
- A low effort non-demand intervention consisting of contacting a patient via validating postcards, letters, or text messages
- A reminder to someone transitioning from acute care that others care about them and there are always resources to navigate a crisis
- Recommended reading: https://highline.huffingtonpost.com/articles/en/how-to-help-someone-who-is-suicidal/ (Jason Cherkis, Huffpost, 11/15/18)

Caring Contacts Process

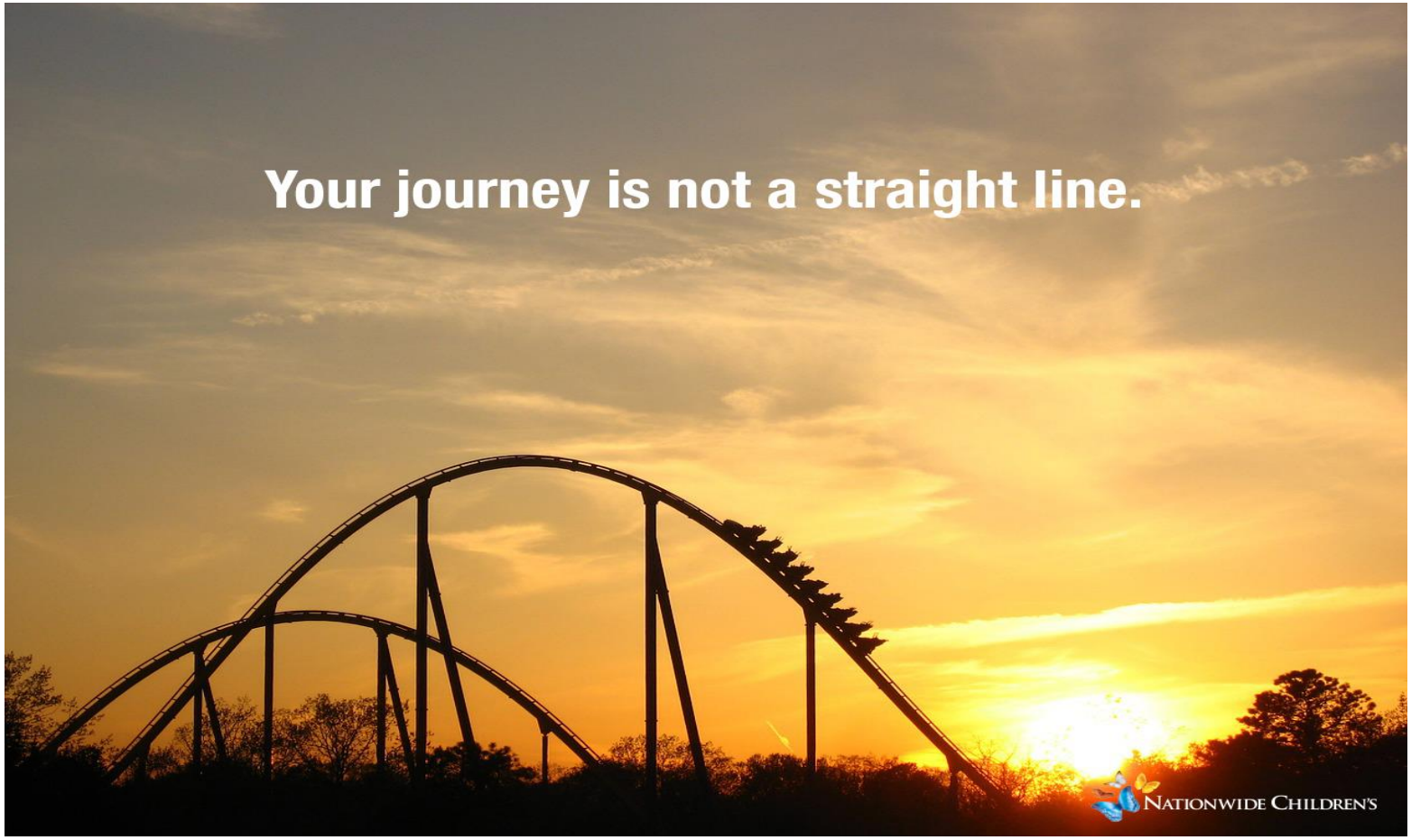
Inclusion criteria:

- Youth >12 years old who present with suicidal ideation or behavior as indicated by positive ASQ and/or C-SSRS
- Youth will receive a one-way caring contact text containing validating language to support them in their care transition
- Texts will be sent 1, 8, 15, 22, 29, 60, 90, and 120 days after discharge from NCH inpatient units or ED
- Youth may also opt out by replying “STOP” to texts

Caring Contacts process

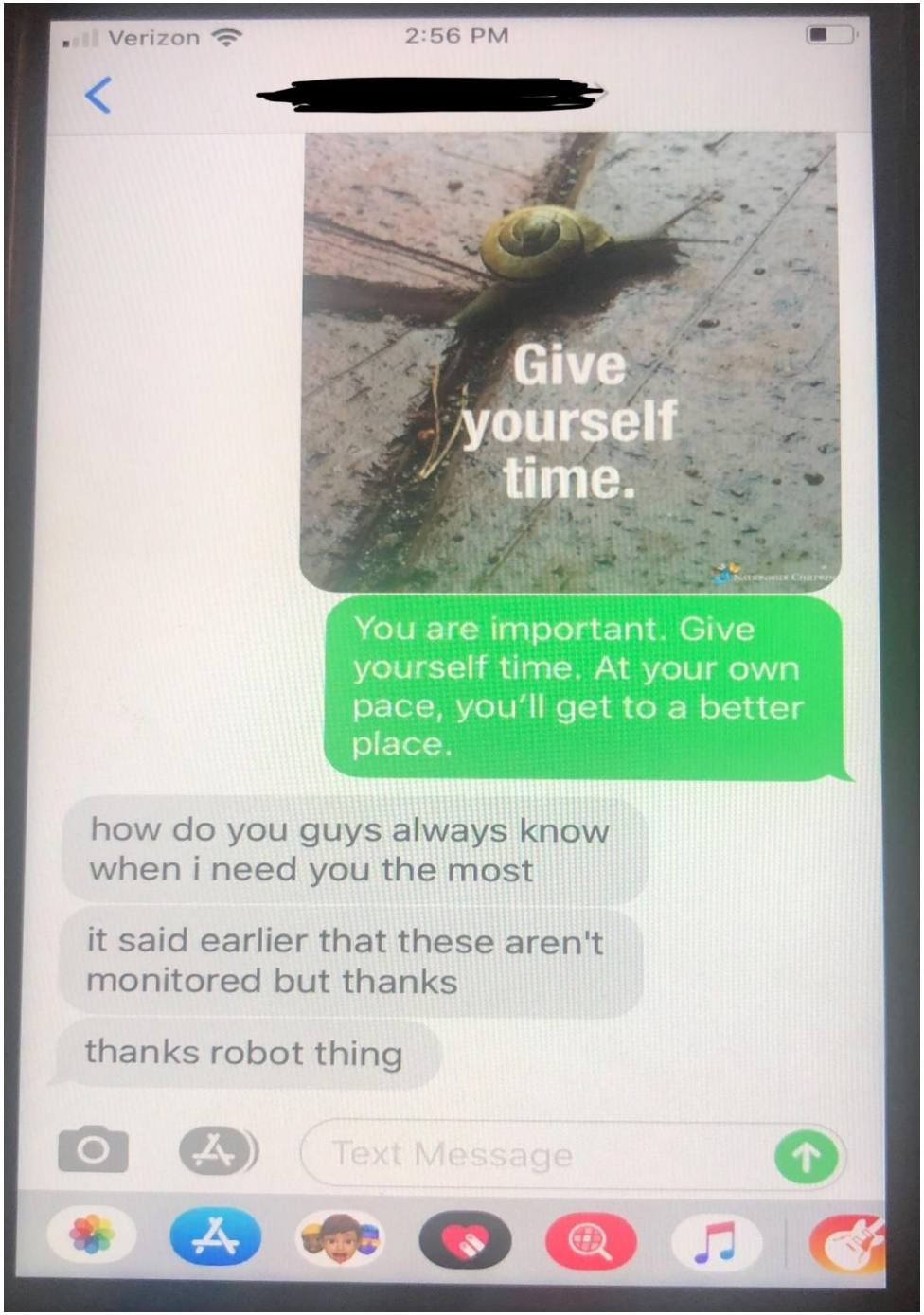
Development of caring contacts

- Feedback from individuals with lived experience
- Texts developed in collaboration with NCH marketing
- Reviewed language: attention validation and non-demand characteristics
- Focus groups with providers and patients
- Revised content and images
- Worked with legal services to revise consent forms
- Partnered with Bandwidth and NCH Research IS to develop automated infrastructure
- Piloted and revised automation process
- Implemented automated caring contacts on 3/10/20



No one's journey is a straight line. Your journey has a purpose.

These text messages cannot be replied to. If you are in crisis or are thinking about hurting yourself, please refer to your safety plan or call Franklin County Youth Psychiatric Crisis Line at 614-722-1800 or text 4HOPE at 741741. For emergencies dial 911.


Verizon
2:56 PM
[redacted]
Give yourself time.
You are important. Give yourself time. At your own pace, you'll get to a better place.
how do you guys always know when i need you the most
it said earlier that these aren't monitored but thanks
thanks robot thing
Text Message

Pediatric Vital Signs

Zero Hero℠
Create a safe day. Every day.

Infant Mortality

Kindergarten Readiness

High School Graduation

Teen Pregnancy

Obesity

Suicide

Preventive Care Index

Child Mortality Rate

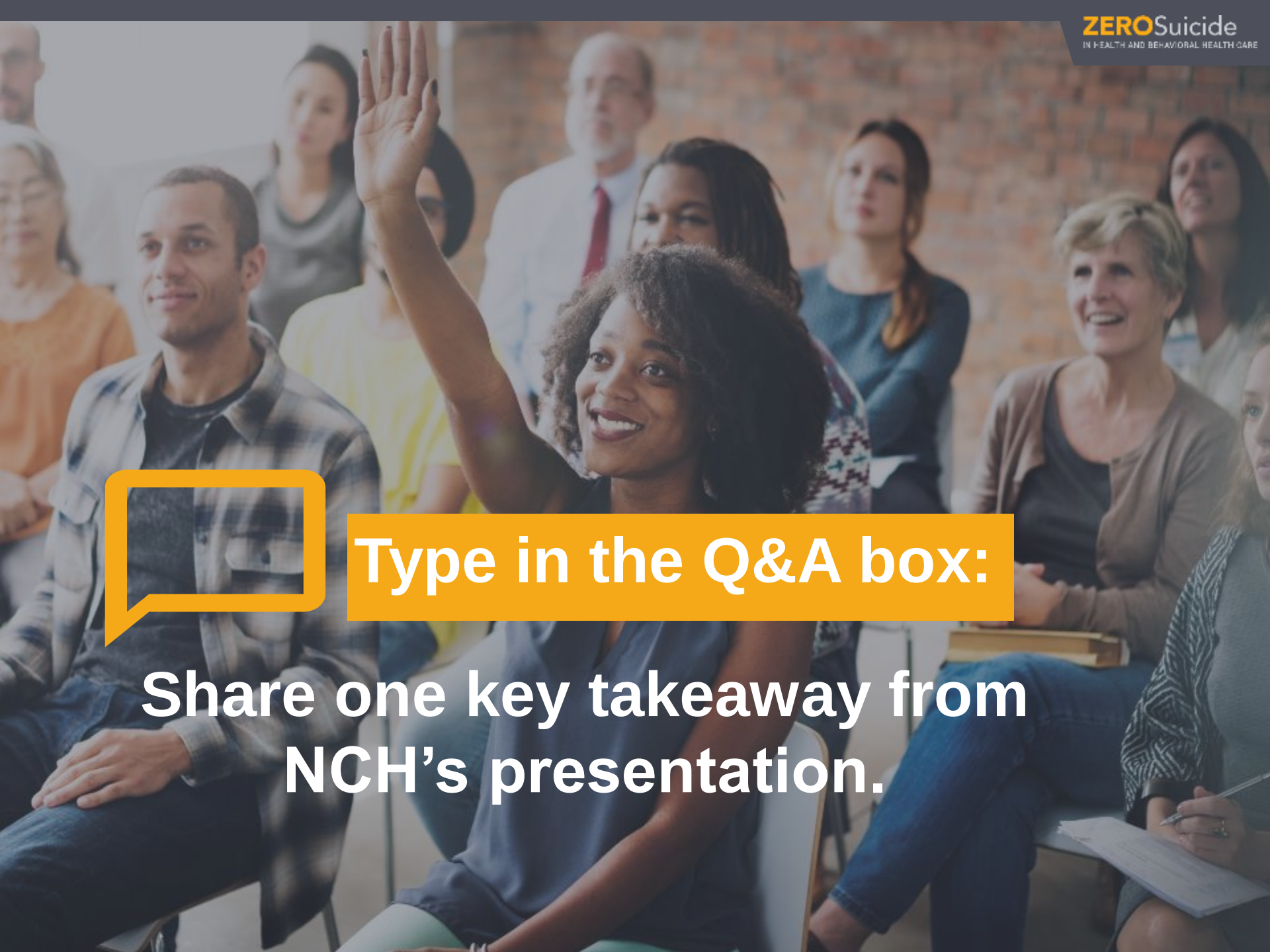
Contact Information

The Center for Suicide Prevention and Research
http://www.nationwidechildrens.org/suicide-prevention
Phone: 614-355-0850

Email:

- John.Ackerman@nationwidechildrens.org
- suicideprevention@nationwidechildrens.org
- Glenn.Thomas@nationwidechildrens.org

Thank you



Type in the Q&A box:

Share one key takeaway from NCH's presentation.

Presenters

Stephen Soffer, PhD

Children's Hospital of Philadelphia®

Jason Lewis, PhD

Perelman School of Medicine
University of Pennsylvania

Agenda

1) Standardization of suicide risk assessment practices through integration of *C-SSRS* in the electronic health record
2) Development of a clinical pathway guiding clinicians in using best-practice suicide-risk assessment and intervention strategies

Suicide Workforce SURVEY RESULTS

107 staff members responded to the survey:

(80 licensed behavioral health clinicians, 14 behavioral health trainees, 4 nursing staff, 9 administrative/support personnel)

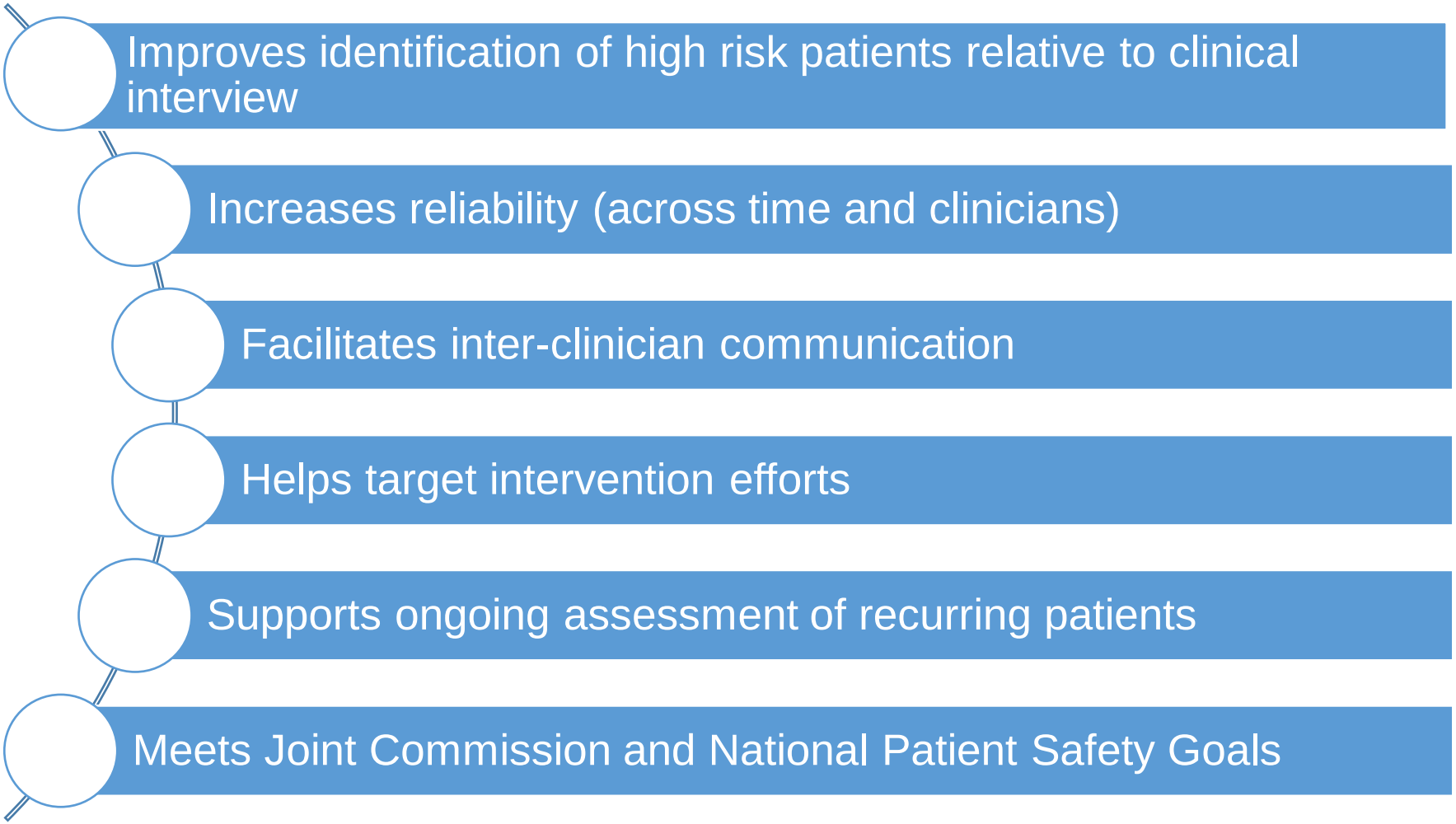
	Strongly Agree or Agree	Neutral	Strongly Disagree or Disagree
I have the support I need to assist people with suicidal desire and/or intent.	**66%**	**17%**	**10%**
I am confident in my ability to manage a patient's suicidal thoughts and behavior	**56%**	**24%**	**12%**
I am satisfied with current processes at this institution for suicide risk assessment and safety planning	**32%**	**35%**	**22%**

67% of respondents (n=64) indicated that they desired formal screening and assessment practices

Standardizing Pediatric Suicide Risk Assessment with the *C-SSRS*

Standardized Suicide Risk Assessment

Comprehensive, standardized risk assessment:



C-SSRS – Training and Implementation

Step 1 – Training

- Developed staff training module with didactics and practice vignettes (3 hours)
- 300 + clinicians, trainees, and social workers trained since October 2016
- Pre/Post test results include statistically significant increases in participant:
  - Knowledge (54%), Comfort with assessment (7%), Ability to assess suicide risk (13%), Received training needed (25%)

Step 2- Implementation

- Integrated *C-SSRS* in Epic EMR workflow (required to close encounter at all visits)
  - Included documentation of associated risk and protective factors
- Developed Best Practice Advisories (BPA) to prompt clinicians to add suicide specific problems to the Epic Problem List depending on *C-SSRS* responses
- Implemented the *C-SSRS* in entire CHOP Dept. of Child and Adolescent Psychiatry and ED

C-SSRS New Patient

Suicidal Ideation

1. Wish to be Dead

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead? Have you wished you were dead or wished you could go to sleep and never wake up? Do you ever wish you weren't alive anymore?

If yes, describe:

Insert SmartText

Lifetime	Past 1 month
No / Yes	No / Yes

2. Non-Specific Active Suicidal Thoughts

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you thought about doing something to make yourself not alive anymore? Have you had any thoughts about killing youself?

Lifetime	Past 1 month
No / Yes	No / Yes

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."

Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

Lifetime: No / Yes

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

When you thought about making yourself not alive anymore (or killing youself), did you think that this was something you might actually do? This is different from (as opposed to) having thoughts but knowing you wouldn't do anything about it.

Lifetime: No / Yes

5. Active Suicidal Ideation with Specific Plan and Intent

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it? What was your plan? When you made this plan (or worked out these details), was there any part of you thinking about actually doing it?

Lifetime: No / Yes

If Yes to questions 2, 3, 4, or 5, please describe:

Insert SmartText

C-SSRS Follow-up Visits

Suicidal Ideation

1. Wish to be Dead

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead? Have you wished you were dead or wished you could go to sleep and never wake up? Do you ever wish you weren't alive anymore?

Since Last Visit: No / Yes

If yes, describe:

Insert SmartText

2. Non-Specific Active Suicidal Thoughts

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you thought about doing something to make yourself not alive anymore? Have you had any thoughts about killing youself?

No / Yes

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."

Since Last Visit: No / Yes

Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

No / Yes

When you thought about making yourself not alive anymore (or killing youself), did you think that this was something you might actually do? This is different from (as opposed to) having thoughts but knowing you wouldn't do anything about it.

5. Active Suicidal Ideation with Specific Plan and Intent

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

No / Yes

Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it? What was your plan? When you made this plan (or worked out these details), was there any part of you thinking about actually doing it?

If Yes to questions 2, 3, 4, or 5, please describe:

Insert SmartText

Risk Assessment

Instructions

Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injurious Behavior

- ☐ None
- ☐ Actual suicide attempt
- ☐ Interrupted attempt
- ☐ Aborted or self-interrupted attempt
- ☐ Other preparatory acts to kill self
- ☐ Non-suicidal self-injury (NSSI)
- ☐ Any suicidal or self-injurious behavior within the last 3 months

List any suicidal behaviors (with dates if possible):

Insert SmartText

Precipitants/Stressors

- ☐ None
- ☐ Medical illness or chronic pain
- ☐ Exposure to violence
- ☐ Social isolation
- ☐ History of abuse or neglect
- ☐ Concerns regarding sexual orientation or gender identity
- ☐ Triggering events leading to humiliation, shame or despair
- ☐ Recent or anticipated losses or other significant negative life events (legal, financial, death, relationship)
- ☐ Bullying or significant peer conflict
- ☐ Other

Psychiatric Risk Factors

- ☐ None
- ☐ Anhedonia
- ☐ Disruptive behavior
- ☐ Homicidal Ideation
- ☐ Highly impulsive behavior
- ☐ Major Depressive Episode
- ☐ Irritability or Agitation
- ☐ Substance use or dependence
- ☐ Aggression towards others
- ☐ Other
- ☐ Presence of other Axis I diagnosis
- ☐ Command hallucinations
- ☐ Severe anxiety
- ☐ Hopelessness

Other Risk Factors

- ☐ None
- ☐ Family history of Axis I diagnosis requiring hospitalization
- ☐ Impaired problem solving
- ☐ Refuses or feels unable to agree with safety plan
- ☐ Hopeless or dissatisfied with treatment
- ☐ Other
- ☐ Family history of suicide attempts
- ☐ Access to firearms or other lethal means
- ☐ Suicide contagion
- ☐ Perceived burden to family or others
- ☐ Non-compliant with treatment

Protective Factors

- ☐ No history of self-injury or suicidal behavior
- ☐ No access to firearms
- ☐ Restricted access to other lethal means
- ☐ Consistent mental health care utilization
- ☐ Positive therapeutic relationships
- ☐ Response to mental health treatment
- ☐ Ability to cope with stress
- ☐ Religious or spiritual beliefs
- ☐ Belief that suicide is wrong or immoral
- ☐ Good frustration tolerance
- ☐ Absence of psychosis
- ☐ Identifies reason for living
- ☐ Good impulse control
- ☐ Healthy problem solving skills
- ☐ Social support
- ☐ Fear of death or dying due to pain and suffering
- ☐ Engaging in work or school
- ☐ Responsibility to family or pets
- ☐ Other

BestPractice Advisories

Advisory (Advisories: 3)

Suicidal Ideation was endorsed on the C-SSRS. Click Accept to add "Suicidal Ideation" to the patient's Problem List.

Add Problem | Do Not Add — **Suicidal ideation** › Edit details

✔ Apply Selected

Suicidal behaviors were endorsed on the C-SSRS. Click Accept to add "Suicidal Behavior" to the patient's Problem List.

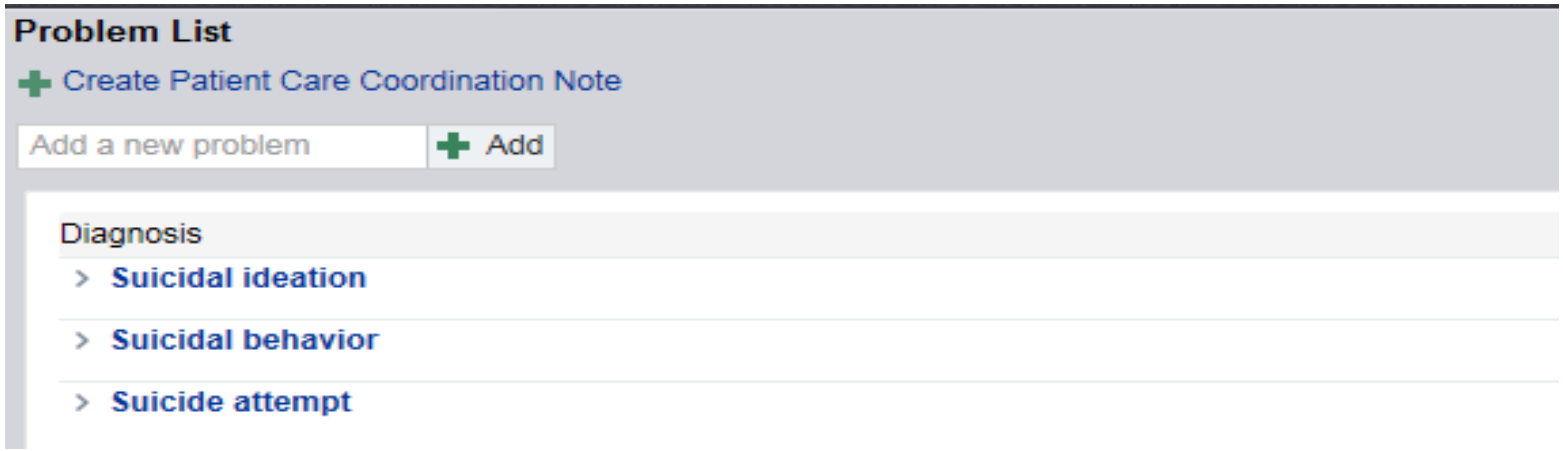
Add Problem | Do Not Add — **Suicidal behavior** › Edit details

✔ Apply Selected

Suicide attempts were endorsed on the C-SSRS. Click Accept to add "Suicide Attempt" to the patient's Problem List.

Add Problem | Do Not Add — **Suicide attempt** › Edit details

✔ Apply Selected

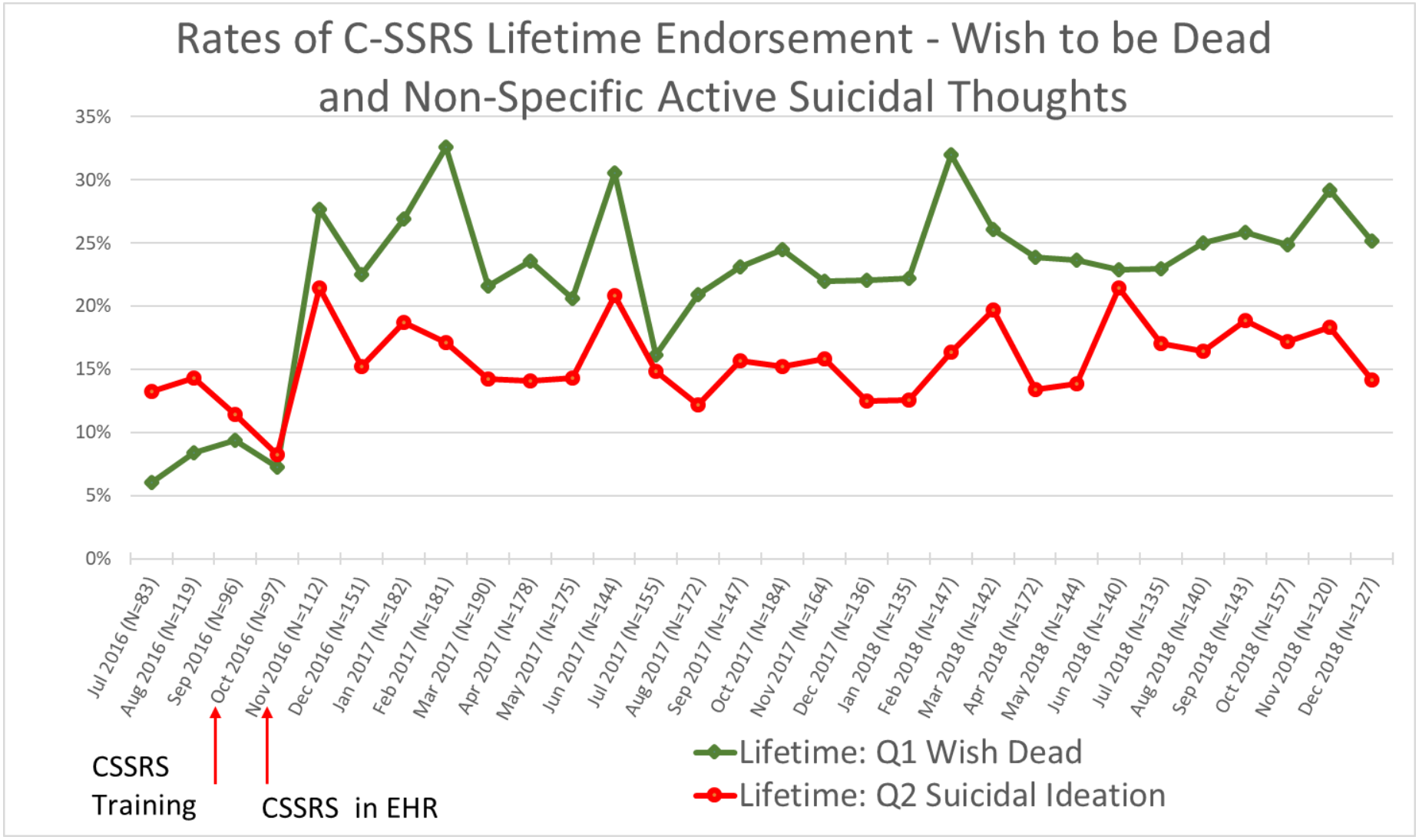


C-SSRS Epic Data

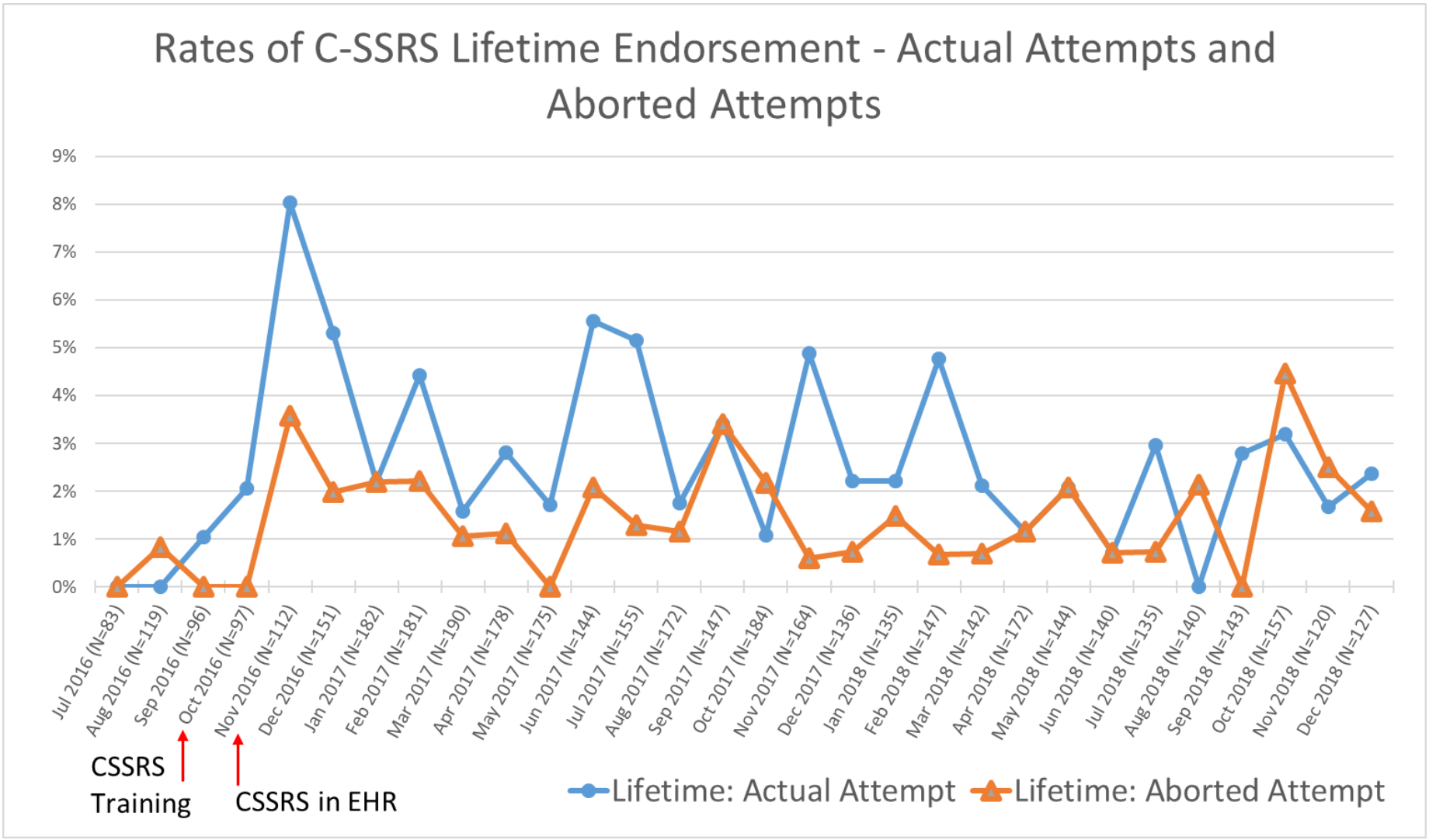
C-SSRS Completion

- Compliance with completing *C-SSRS* for new patients is close to %100
- *C-SSRS* completed (FY 2017-2020):
  - Total = 22,916 patients with *C-SSRS* completed
  - New patient (Lifetime) = 19,217 patients
  - Follow-up (Since Last Contact) = 14,808 patients
  - Total visits with any *C-SSRS* completed = 122,712

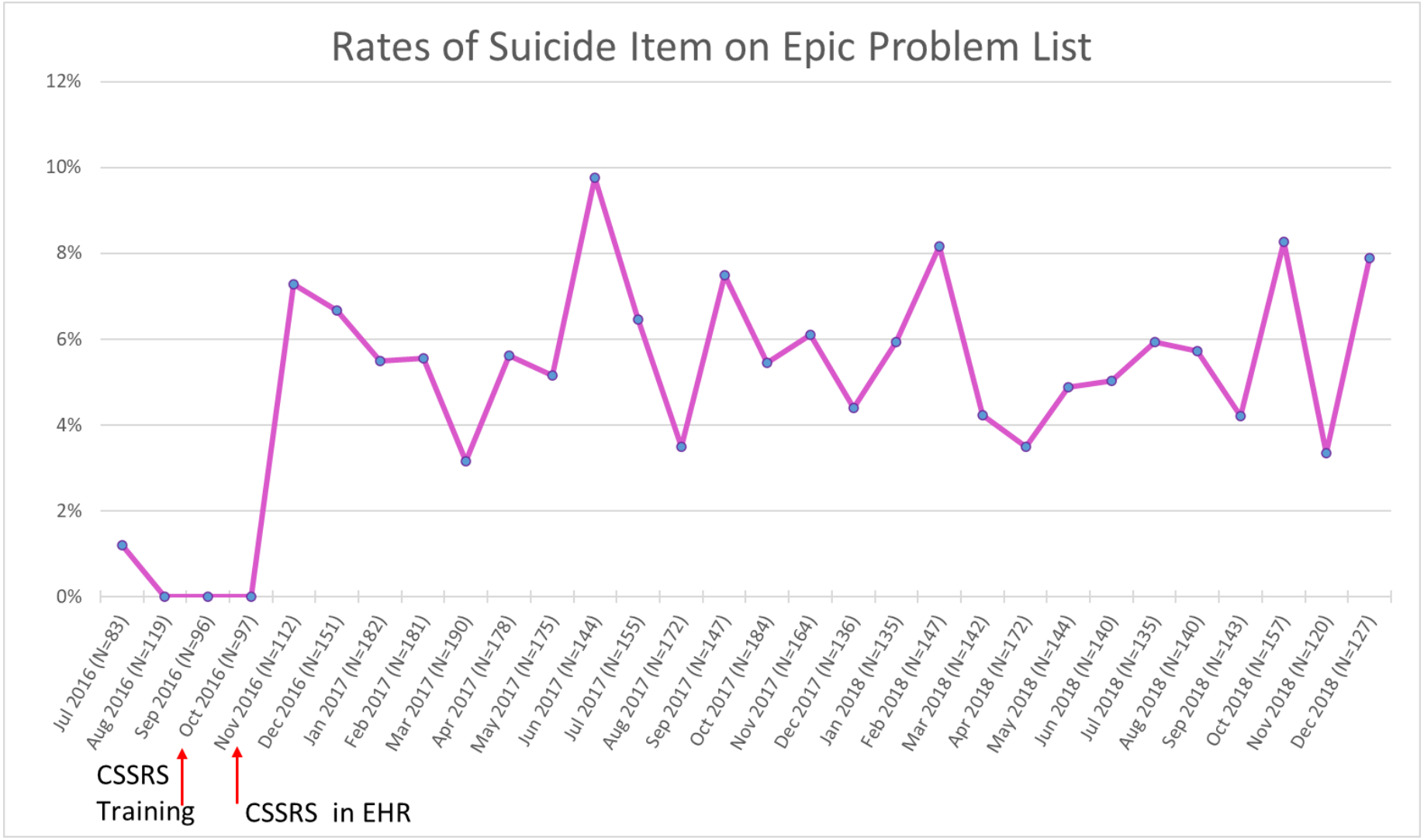
Standardized Assessment Increases Identification



Standardized Assessment Increases Identification



Standardized Assessment Increases Identification



Clinical Pathway Development

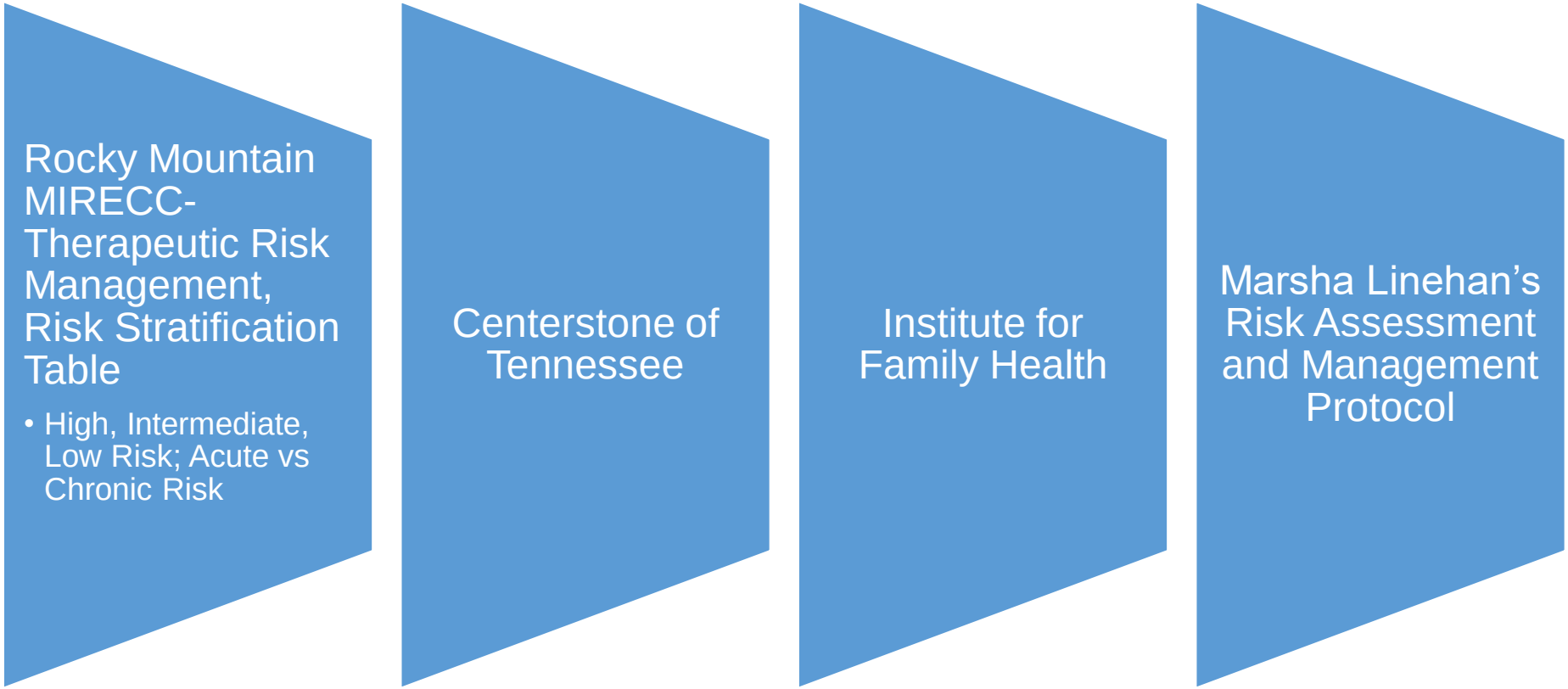
What Are Clinical Pathways?

Structured plans of care that translate guidelines and/or evidence into localized infrastructure and processes.

Provide guidance on the evaluation and management of given chief complaints, diagnoses, or clinical processes that can be applied across the care continuum.

Aim to standardize care for a specific clinical problem, process, procedure, or episode in a defined population, such that variation resulting from specific patient characteristics is preserved whereas variation from the provider is eliminated.

Benchmarking of Existing Pathways and Care Management Plans



Key Takeaway- A scarcity of clinical pathways directed at youth at risk for suicide

Suicide Care Clinical Pathway- Goals

Accurate and consistent identification of youth who present with elevated risk for suicidal behavior.

Provide guidance to clinical teams to support clinical decision making and standardize care for children in outpatient settings presenting with current, recent, or past suicidal ideation and/or behavior

Improve clinical outcomes by increasing the likelihood that youth requiring higher levels of care or suicide-specific care are identified and connected with the needed treatment.

Suicide Care Pathway- Timeline of Development

April 2017- Pathway Proposal submitted to CHOP Office of Clinical Quality Improvement (OCQI)

July 2018- Proposal accepted and began working with OCQI Improvement Advisor

Twice monthly meetings between ZS team and Improvement Advisor

Published in June 2019

https://www.chop.edu/clinical-pathway/suicide-risk-assessment-and-care-planning-clinical-pathway

Outpatient Behavioral Health Care Clinical Pathway for Assessment and Care Planning for Children and Adolescents at Risk for Suicide

Goals and Metrics

Patient Education

Provider Resources

Related Pathway

Behavioral Health Issues, ED

Depression, Outpatient Behavioral Health and Primary Care

Patient with Possible Suicide Risk

Screen for Suicide Risk

Positive Suicide Screen/New Patient Evaluation

Definitions

Suicidal Ideations, Behaviors, Non-suicidal Injury

Negative Suicide Screen

Screen for Suicide Risk at subsequent patient care encounters.

Engage and/or continue treatment plan on primary presenting symptoms and problems.

Use the Columbia Suicide Severity Rating Scale to complete Suicide Risk Assessment

Assess for chronic and current Risk and Protective Factors

Negative Suicide Risk Assessment

Complete Risk Formulation.

Engage and/or continue treatment plan on primary presenting symptoms and problems.

Screen for Suicide Risk at subsequent patient care encounters.

Low Acuity

Suicidal Ideation

At least 1 of the following:

Within the past 1 month:

Wish to Be Dead

More than 1 month ago:

Non-specific Active Suicidal Thoughts

Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Within past 3 months:

Non-suicidal Self-injurious Behavior

And

Suicidal Behavior

No History of Suicidal Behavior

Intermediate Acuity

Suicidal Ideation

At least 1 of the following:

Within the past 1 month:

Non-specific Active Suicidal Thoughts

Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

More than 1 month ago:

Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active Suicidal Ideation with Specific Plan and Intent

And/or

Suicidal Behavior

More than 3 months ago:

Suicidal Behavior

High Acuity

Suicidal Ideation

At least 1 of the following:

Within the past 1 month:

Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active Suicidal Ideation with Specific Plan and Intent

And/or

Suicidal Behavior

Within the past 3 months:

Suicidal Behavior

Evidence

Assessment and Management of Suicide Risk in Children and Adolescents

Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk

The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults

Community Resource

Columbia Suicide Severity Rating Scale

Joint Commission Sentinel Event Alert

Therapeutic Risk Management – Risk Stratification Table

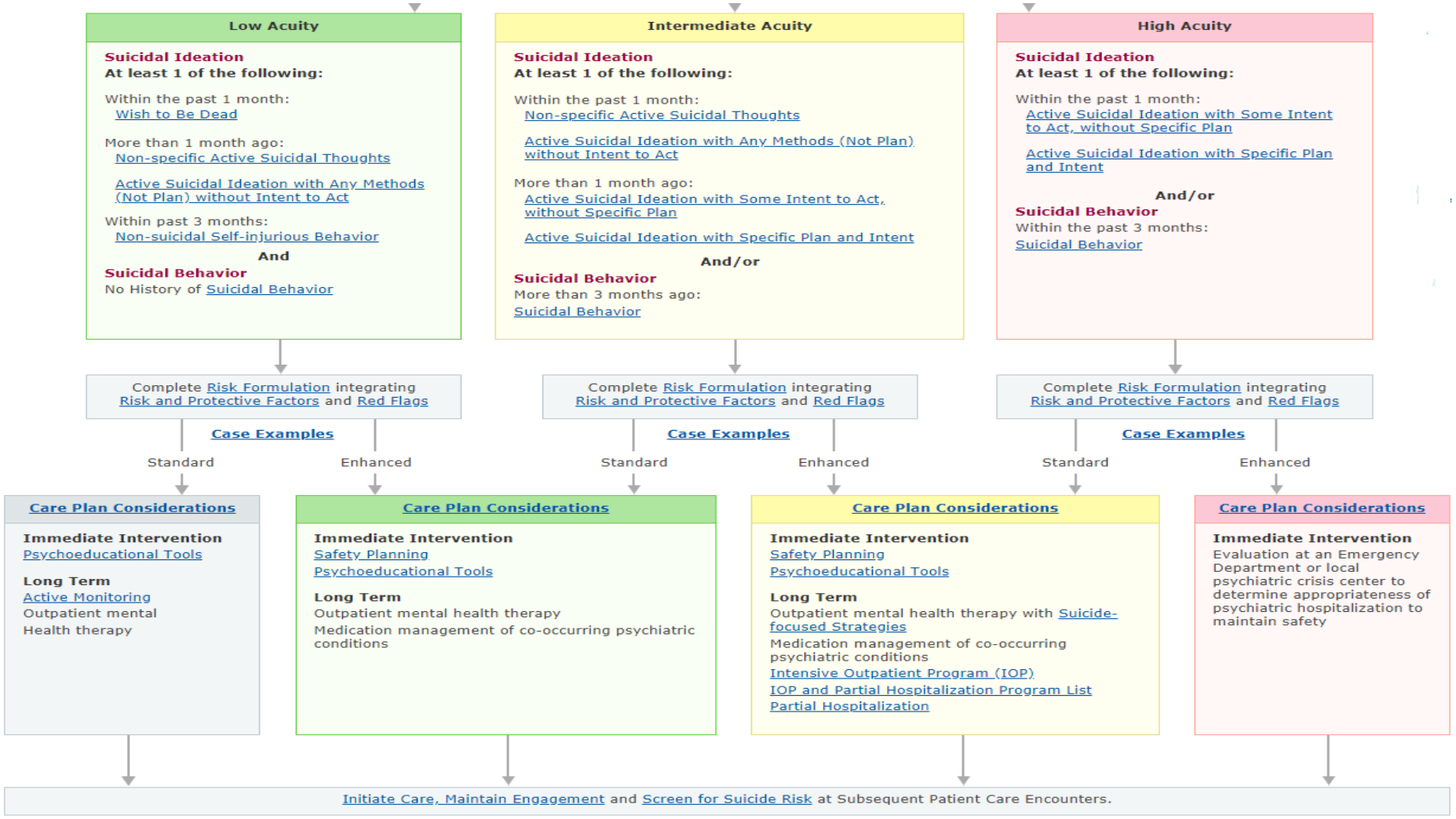
IOP and Partial Program Resource List

How to Apply for Medical Assistance in PA or NJ

CHOP Programs

Child and Adolescent Psychiatry and Behavioral Sciences

Youth Suicide Prevention, Intervention and Research Center


Low Acuity
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At least 1 of the following:
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Non-specific Active Suicidal Thoughts
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Within past 3 months:
Non-suicidal Self-injurious Behavior
And
Suicidal Behavior
No History of Suicidal Behavior
Intermediate Acuity
Suicidal Ideation
At least 1 of the following:
Within the past 1 month:
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More than 1 month ago:
Active Suicidal Ideation with Some Intent to Act, without Specific Plan
Active Suicidal Ideation with Specific Plan and Intent
And/or
Suicidal Behavior
More than 3 months ago:
Suicidal Behavior
High Acuity
Suicidal Ideation
At least 1 of the following:
Within the past 1 month:
Active Suicidal Ideation with Some Intent to Act, without Specific Plan
Active Suicidal Ideation with Specific Plan and Intent
And/or
Suicidal Behavior
Within the past 3 months:
Suicidal Behavior
Complete Risk Formulation integrating Risk and Protective Factors and Red Flags
Case Examples
Standard
Enhanced
Care Plan Considerations
Immediate Intervention
Psychoeducational Tools
Long Term
Active Monitoring
Outpatient mental Health therapy
Immediate Intervention
Safety Planning
Psychoeducational Tools
Long Term
Outpatient mental health therapy
Medication management of co-occurring psychiatric conditions
Immediate Intervention
Safety Planning
Psychoeducational Tools
Long Term
Outpatient mental health therapy with Suicide-focused Strategies
Medication management of co-occurring psychiatric conditions
Intensive Outpatient Program (IOP)
IOP and Partial Hospitalization Program List
Partial Hospitalization
Immediate Intervention
Evaluation at an Emergency Department or local psychiatric crisis center to determine appropriateness of psychiatric hospitalization to maintain safety
Initiate Care, Maintain Engagement and Screen for Suicide Risk at Subsequent Patient Care Encounters.

Patient with Possible Suicide Risk

This pathway should be used to guide the screening, assessment, and care planning of patients at risk for suicidal ideation and/or suicidal behavior in an outpatient behavioral health setting:

- Patients with behavioral or emotional concerns, or screening positive on a depression questionnaire like the PHQ-9
- Patients with chronic or acute medical illness
- Patients who have had a decline in overall clinical/behavioral/emotional functioning
- Patients with recent suicidal ideation or behavior

It is important for clinicians to know and be aware of the presence of risk factors for suicidal ideation and/or behavior to ensure that patients are appropriately screened and referred for further assessment and treatment by behavioral health providers.

Exclusions

Patient ≤ 3 years

Suicide Risk Assessment and Care Planning Clinical Pathway — Outpatient Specialty Care

Suicide Risk Assessment using the Columbia Suicide Severity Rating Scale

Suicide risk assessment gathers information related to current and past history of suicidal ideation, suicidal behavior, and self-injurious behavior. The widely used Columbia Suicide Severity Rating Scale (C-SSRS; Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann, 2009) is a standardized, evidenced-based instrument that guides a thorough and reliable suicide risk assessment.

A standardized approach to assessment, using the C-SSRS, supports reliability and clear communication across clinicians and clinical teams using specific definitions of suicidal ideation and behavior, as well as ratings of intensity and severity of ideation and behavior.

The C-SSRS is applicable across multiple settings in the health care environment (e.g., inpatient, outpatient, ED) and does not require a mental health clinician to administer.

The C-SSRS can be used for both initial encounters with patients, as well as in the context of follow-up care of established patients to track changes over time. The completion of the C-SSRS will assist with the development of a risk formulation and plan of care to address the patient's immediate and ongoing needs.

- C-SSRS — Very Young Child/Cognitively Impaired – Lifetime Recent
- C-SSRS — Very Young Child/Cognitively Impaired – Since Last Contact
- Columbia Protocol for Communities and Healthcare

Risk Factors and Protective Factors

A sense of a patient's overall risk is formulated by integrating the results of the clinical interview with patient and caregiver(s), suicide risk assessment, and weighing the balance of the patient's unique risk and protective factors. Patients who have multiple risk factors, particularly in the absence of protective factors, may benefit from enhancing the intervention plan to include a greater level of support and responsiveness.

Risk factors represent aspects of the patient's clinical presentation, history, environment, family and social context, and demographics that precede suicidal behavior, and may increase risk for suicidal behavior or suicide. Risk factors are important to assess and integrate into a risk formulation as they may increase a patient's risk for suicidal behavior, beyond the presence of past and/or current suicidal ideation and behavior.

Protective factors are important to assess and understand, as they may decrease the risk of suicidal behavior or suicide. Protective factors can also help with treatment planning, as patients with more protective factors may need less intense treatment approaches compared with patients who do not have as many protective factors.

Patients and families who are able to: a) **maintain safety** in their current environment, b) engage in using **coping strategies**, c) willing and able to **follow treatment plan** recommendations, and d) apply the steps of a **safety plan in a crisis situation** are at reduced risk compared with patients and families who are not able to demonstrate these factors.

	Risk Factors	Protective Factors
Clinical	History of multiple suicide attempts History of chronic, intense suicidal ideation Non-suicidal self-injury Psychiatric disorders Patient with new onset or worsening: Impulsivity Substance use Aggression Poor sleep Poor distress tolerance	No history of self-injury or suicidal behavior Engaged in and responsive to mental health treatment Absence of psychosis Good impulse control
Psychological	Hopelessness Poor emotional regulation and/or mood swings Limited problem solving and coping skills Lack of experience of enjoyment/pleasure	Fear of death or dying due to pain, suffering Religious or spiritual beliefs Belief that suicide is wrong or immoral Healthy problem solving Ability to cope with stress Good frustration tolerance Identifies reasons for living

Case Example (Intermediate Acuity)

Tommy and Brandon are 16-year-old males who receive outpatient mental health treatment for depression. During today's individual appointments, Tommy and Brandon both reveal suicidal ideation with method within the last month, placing them both at intermediate acuity based on their suicide risk assessment using the C-SSRS.

Brandon has a history of suicidal ideation but no history of suicidal behavior. He has been engaged in treatment and has shown good response to medications and individual therapy so far, but is struggling recently in the context of academic stressors and peer conflict. Brandon's family is felt to be a strong source of support. There are no other red flags.

Brandon's clinician weighs this additional information when formulating Brandon's overall risk.

Brandon would benefit from standard treatment recommendations including Suicide Safety Planning with Brandon and his family, increasing the frequency of individual outpatient therapy, and continuing medication management services.

Tommy also has a diagnosis of ADHD, can be impulsive, and is intermittently compliant with treatment recommendations. He has a history of red flags, including punching walls and burning his skin when he is upset. His mother also reports that Tommy recently came home after curfew from a party and appeared to be intoxicated.

Tommy's clinician weighs this additional information when formulating Tommy's overall risk.

Tommy would benefit from enhanced treatment recommendations including suicide safety planning with Tommy and his family, incorporating suicide-specific skills and strategies into the individual therapy, continuing medication, and referral to intensive outpatient programming.

Interventions

Active Monitoring	Active monitoring emphasizes all of the important things that can occur BEFORE initiating a formal psychotherapeutic or pharmacological treatment to address a patient's suicide risk. The following list contains some of the elements of active monitoring: Schedule frequent visits to assess for changes in clinical presentation Prescribe regular exercise and leisure activities Recommend a peer support group within community Review self-management goals and engage in problem solving strategies Follow up with patients via telephone in between sessions Provide patients and families with patient educational materials Refer to the Glad PC Tool Box for more guidance on active monitoring.
Community-based Services	A targeted service designed to stabilize a child in their community, support success during transitions, and reintegrate a child when returning home following more intensive treatment. The goal is to provide treatment in the least restrictive environment, while maintaining the child within his or her community.
Suicide-focused Strategies	There are evidence-based therapies that are specifically focused on targeting suicidal thoughts and behaviors, and the factors that contribute to and maintain them. Examples of these therapies include: a) Collaborative Assessment and Management of Suicidality (CAMS); b) Cognitive Behavior Therapy – Suicide Prevention (CBT-SP); and c) Dialectical Behavior Therapy (DBT). Please refer to Zero Suicide: Interventions for descriptions of these treatment approaches.
Intensive Outpatient Program	An outpatient mental health therapeutic intervention more structured and intensive than traditional outpatient therapy. Intensive Outpatient Programs usually meet 2-3 times per week and often involve individual, family, and group therapy.
Partial Hospitalization Program	Outpatient mental health programs that patients attend for six or more hours a day, every day or most days of the week. These programs, which are less intensive than inpatient hospitalization, will commonly offer group therapy, educational sessions and individual counseling. A PHP may be part of a hospital's services or a freestanding facility.
Safety Planning	A brief (20-45 minute) intervention that results in a prioritized list of warning signs, coping strategies, and resources to use during a suicidal crisis. Example Safety Plan Template

Patient Education

- Child Abuse and Suicide
- Depression in Children and Teens
- Firearms and Children
- LGBTQ Youth and Suicide
- Self-injury in Adolescents
- Suicide in Children and Teens
- Talking to Your Kids about Suicide

THANK YOU!

CHOP Zero Suicide Workgroup

- Steve Soffer, PhD
- Jason Lewis, PhD
- O'Nisha Lawrence, MD
- Yesenia Marroquin, PhD

Want to view our Youth Suicide Care Pathway??

Go to – https://www.chop.edu/clinical-pathway/suicide-risk-assessment-and-care-planning-clinical-pathway

Want to learn more about Suicide Prevention Efforts at CHOP??

Go to – https://www.chop.edu/centers-programs/youth-suicide-prevention-intervention-and-research-center

Type in the Q&A box:

Share one key takeaway from CHOP's presentation.

Type in the Q&A box:

What questions do you have for our presenters?

ZEROSuicide

Thank you for joining systems nationwide striving for zero suicide among patients in care.

www.zerosuicide.com

APPLYING ZERO SUICIDE IN PEDIATRIC CARE SETTINGS
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>> JULIE GRUMET: Welcome, we want welcome you to the pediatric care settings room. My name is Julie Goldstein Grumet. We're asking people to take a moment to introduce themselves please include, your name, your organization, your state. We would like to know a little bit about who is in the room with us today. We have a couple minutes while we allow people in the room. But please go ahead. We look forward to this time spent with you.

Good afternoon. This is our webinar on applying Zero Suicide in pediatric care settings. I'm Julie Goldstein Grumet. Please go ahead and introduce yourself so we know who's in the room. It's always exciting to see how far and wide this webinar is going. We would love to know your organization and the city and state you're calling in from.

I can see people calling in from New York, Illinois, Virginia, Colorado, Pennsylvania, people having lunch with us today. I'm here in Maryland, just outside Washington, DC. One of our better days with less humidity, people calling in from Ohio. Sometimes we get international folks. I'm trying to find somebody from international for the prize. I see New Mexico. You might be the farthest right now. I hope you guys are doing well. Oh, Nairobi, you might be the winner. Glad you are able to join us. I don't know if it's in the middle of the night or not. Really appreciate you calling in today.

We're going to take about 30 seconds more to make sure everybody's in the room. This is the applying Zero Suicide in pediatric care settings webinar. We do multiple webinars to help bring the Zero Suicide framework to you and help you to better understand and operationalize it. I'm Julie Goldstein Grumet. We're going to get started in just a moment. So continue to go ahead

and type in your name and organization. I'm going to turn it over in about two seconds over to Keri for a tech tip.

I appreciate the diversity of locations in Connecticut, Oklahoma. I see Canada. Happy to have you all join us today. Keri, I'm going to turn it over to you now for our tech tips.

>> KERI LEMOINE: Great. Thanks, Julie. Welcome, everybody. For this webinar, the phone lines will be muted for the duration of it. If you have any questions or comments throughout the presentation, please type them in the Q&A box located on the left-hand side of your screen. We will be recording this meeting and the slides will be available after the presentation. Thank you for attending. I'll pass it back.

>> JULIE GRUMET: Great. Thank you we have a great session for you today. It's applying Zero Suicide in a pediatric care setting. I'm Julie Goldstein Grumet, the moderator. I'm the director of health and behavioral health initiative for the SPRC SPRC and the director of the suicide institute. We get a lot of questions about doing Zero Suicide with youth. I think you'll find today's webinar really helpful.

As I said I'm with the Suicide Prevention Resource Center. This is federally funded by SAMHSA, the views opinions and content expressed do not necessarily reflect the views, opinions. The Suicide Prevention Resource Center was established in 2002. As I said, federally funded by SAMHSA. SPRC provides the prevention support and serves as a resource destination for anyone interested this in learning more about suicide prevention. We have a wide range of materials. We provide assistance to populations and settings suches a campuses, local communities, federal government, tribes, healthcare systems, individual clinicians, first responders. We really are the academic setting that tries to distill the evidence-based practices and resources available and make them useful for your youth and implementation.

Our resources are free and publicly available including a program called comm that many health staff has taken to have a meaningful conversation for people who are at risk for suicide. We're focused on helping you to operationalize the vast array of tools available.

Provides oversight for operationalizing the model when I'll talk more about in a moment.

So today's focus, as I said, is going to focus on Zero Suicide in pediatric care settings. It doesn't mean the model itself is a significant deviation from the description I'll give you in a moment, but clearly we do need to make sure that it has the relevance for the stakeholders for whom we are focusing it on. Pediatric settings I'm so grateful that the members of today's webinar is going to speak about this, because we know kids are also at risk for suicide.

Certainly when we think about Zero Suicide, it's comprised of seven elements, each of which individually has evidence that reduces suicide and suicide behaviors. When used together in a sustained and systemized way, this bundle of interventions has been

found to reduce suicide in many different healthcare settings, hospitals, outpatient behavioral health, in-patient psych hospitals, emergency departments, primary care. While we often think about starting this initiative within behavioral health, I would that would severely limit the potential it holds because we really want to think about every door is the right door in healthcare for people to be identified and cared for who are at risk for suicide.

We also know that 84% of those who die by suicide have seen a healthcare provider in the year before their death. Many more have made suicide attempts, but we don't ask so we don't always know about these attempts. And these people are not being seen in behavioral but they're being seen often at other visits, whether it's a broken ankle in the emergency room, a primary care visit. 40 to 50% suicide detects have been within a month of seeing a primary care physician. By not recognizing that these are missed opportunities. For kids 10 to 24 suicide is the second leading cause of death. Kids aren't as sick as adults. They shouldn't be. Yet when kids are dying by suicide, we need to stop and think about that and think about the fact that suicide and using these resource also make it more preventible by youth. It should be things that healthcare physicians should be attending to.

Zero Suicide looks at reducing suicide as a highly achievable goal. Some people don't love the name zero. I understand that. I've heard it all. They get stuck on is zero really possible? What does it mean if we don't get to zero? For so long in suicide prevention we set goals to reduce by 10%, 20% or 50%. Those goals are great and noble and certainly difficult but is it sufficient? What are we really aiming for if we're only aiming for small reductions? What if it's your child at risk for suicide or not accounted for by that 10%? When systems apply all that they know about safety like the airline industry or nuclear power plants and their focus is zero disasters, zero is the goal and zero is often achieved. They maintain the safety by applying effective tools that focus on safety as a priority.

To fix the problems that exist and maintaining the belief that failure is absolutely unacceptable. So we won't those same types of standards applied in suicide care. It's possible, the best practices do exist exist. We can and should be applying these tools across healthcare. They're available at Zero Suicide.com. I invite you to take a look at our website which is a strong implementation toolkit.

The seven elements of which I spoke a moment ago, each of them are evidences based but the research is relatively new but it exists. Given that it's new, many providers weren't trained during graduate school or required by CEUs to use the tools and practice them and don't know they exist it. How can you apply something if you don't know that it exists? Singular interventions don't have the same effectiveness that this entire bundle has. Using continuous quality improvement efforts to ensure fidelity to do what we're saying we're doing and making changes is critical to the success of the Zero

Suicide framework.

At its core Zero Suicide has clinical steps that have to be university applied. So we think about routine screening and risk assessment, collaborative safety planning that includes reducing access to lethal means and treatment that directly targets the suicidal thoughts and is also applied into follow-up much like when you get a phone call after you've had surgery to ensure that you're healing effectively, you have your medications are okay, you know when your next appointment is. Again, we have a lot of these processes and protocols in the medical world that we can certainly apply to suicide care.

Though these practices work and we know that they work, they aren't routinely used by most healthcare systems. As I said, that's often because people don't know that they exist. It also, though, is often adopted when leadership is committed to the recognition that suicide prevention should be part of their culture of safety. This type of care should be expected by patients and families and staff.

When staff have the support and the training and tools to do this work, they can be extremely successful. And we have to provide staff with the support, training, and tools in order to care for people at risk for suicide.

Today's webinar we'll discuss how two Children's Hospitals adopted the Zero Suicide model successfully. They'll share some obstacles and how they overcame them and talk about their findings and lessons learned. We're grateful to have them join us today.

This is the toolkit. This is available at Zero Suicide.com. Everything is tagged for different settings and populations you might be working with. There's a toolkit in the resource section that's been adapted working with tribes. There's a tag for youth. I'll show you in a moment a few of the tools specific to use. I would encourage you to join the list serve. They are comprised of people lived with experience running Zero Suicide programs in their own settings. The it's an incredibly generous community that want to share their resources and allow you to share them as well.

This is our implementation toolkit. If you click on the toolkit in the blue bar, it will bring you through the seven elements and the resources available to adopt each of these pieces.

This is the children and youth filtered resources. So you'll see there's things that you'll hear many of our presenters talking about today particularly with regard to pathways that you can check after today's webinar.

So today's webinar in particular is focusing on the adaptations to risk identification, assessment, and care pathways to address suicide in youth serving healthcare systems. We will focus on caring contacts, that intervention can be applied in pediatric settings as well as the importance of leadership and staff training to sustain practice change in pediatric hospital systems.

Our speakers today, the first speaker will be Glenn Thomas, he's the director in behavioral health services at Nationwide Children's Hospital. He's been responsible for a broad range of

services such as child protective services, intervention like multisystemic therapy, crisis services, behavioral health services on in-patient psych units, school-based services. He's responsible for the expansion of mental health and suicide prevention efforts such as the good behavior game or signs of suicide and the Zero Suicide initiative. Joining Glenn is John Ackerman who is a child clinical psychologist and a suicide prevention coordinator for research at Nationwide Children's Hospital.

John supports clinical training of psychologists and social workers and counselors at Nationwide serves on an implementation team that he'll tell you more about and is involved in training on risk assessment and primary care and community settings.

I want to welcome both Glenn and John. Turn it over to them. Again thank them for joining us today.

>> GLENN THOMAS: This is Glenn Thomas. Thank you for joining us. It's a pleasure to be here with you. This is really important work and by way of I want to tell you about Nationwide Children's Hospital. We are the largest behavioral health department at any Children's Hospital in the nation. We have about 600 providers across various disciplines from psychiatry, psychology, social worker, recall family therapy. We have a very broad continuum of services from prevention all the way to in-patient, including crisis services. These high acute services we have significantly expanded over the last roughly eight years.

Just our size and the broad array of services we have was a challenge when it came to designing our implementation of Zero Suicide. So as a result of an increase in the acuity services, we have seen a lot more patients filtering down from higher level of services to all of our services with increased acuity and certainly called in for a more comprehensive response. Just from unique patients. You can see we see a lot of patients in Franklin County in central Ohio and the contiguous area.

We were fortunate in that about 12 years ago, the hospital leadership committed to a quality improvement program that we've called Zero Hero that has been driven very strongly from hospital leadership. It's really become embedded into our culture, focuses on the elimination of preventible a harm and you saw the slide Julie presented on continuous QI. This is very much along the same principles as Zero Suicide. And that consistency has really helped us with the implementation.

So we began in 2017 with our organizational study very quickly after that went to the Zero Suicide academy and immediately formed our implementation team. There was a significant level of commitment and enthusiasm right from the word go due to the recognition that we needed to make sure we provided consistent, comprehensive suicide care across all of our programs.

And our behavioral health medical director, Dr. David axleson kicked this off with an introductory email to all of our staff. Then we began a process of educating from management down to the individual team level and all the clinicians of what Zero Suicide executed and

why we were doing it.

We then implemented our workforce survey. And I think partly or largely because of our consistent communication around it, we actually had a very healthy return rate. At the time we had about 600 people in behavioral health as a whole. We've since grown to about just over a thousand.

We work closely with the SPRC around the Workforce Survey given our size. We broke the survey down by -- into nine categories, largely by discipline and or area within behavioral health because we really wanted to make sure that we get as much possible -- as much information as possible about strengths and challenges in each of our areas.

What we found from the Workforce Survey and also the self-study is we had areas of excellence. There were some places that we were doing best practice screening, assessment, safety planning, means reduction, continuous contact with patients stepping down from a higher level of care into the community. But we had a significant amount of consistency in practice, competence, and then, of course, that bled through to confidence as well.

It became clear that we were not doing the best job we could identifying high acuity patients. We did not have consistent screening or assessment. We didn't have a clear care pathway for patients experiencing suicidal ideation. And our continuing contact, particularly during transitions of care were spoty at best at times.

We took the results as an implementation team and reviewed them. We briefed the leadership team for behavioral health, the directors of all the different areas. And then they were responsible for conveying this to the staff in the areas below them. We did that by providing canned PowerPoints and so on.

Staff was universally open to what they heard. Again, this was a very easy tie-in to our existing Zero Hero QI implementation. Then we kicked off with our monthly implementation team meetings. Initially we were planning on having this be a group of about nine people. There was overwhelming enthusiasm. We had requests from all areas of behavioral health to be involved. And so we ended up expanding the committee significantly.

We had a young woman who represented lived experience who had been on a crisis stabilization unit and received outpatient care. We were lucky enough to have QI resources. So we had our behavioral health QI representative, two psychiatrists, and then fortuitously we had just created the behavioral health education department. And the person who directs this department was very familiar with our electronic medical record. We happen to use EPIC. So she was instrumental in engaging our IS team in developing EPIC. You'll hear from John Ackerman more about that later.

We built it to make it easier for clinicians but also so that we could easily access data from a continuous improvement perspective, so we could see how we were doing.

Here is our timeline. I've gone over most of this. I will

say we did a pilot starting in the third quarter of 2018. We were expecting to do three pilots, but at that point once we had decided what we wanted the EMR to look like, our IS team made such rapid progress that we only did the one pilot wrapped up training. And then we went live in July of 2019, largely driven by the Joint Commission's change standards effective July of 2019.

And then we were lucky to have a grant to implement our caring contacts initiative that John will talk about a bit more. The last two quarters were devoted to examining data which we'll touch on in just a minute.

John, I'm handing over to you.

>> JOHN ACKERMAN: Absolutely. Thank you, Glenn, for providing such great context to what we've been doing at Nationwide Children's Hospital. As Dr. Thomas noted, leadership input and buy-in were critical throughout the entire Zero Suicide process and was true for staff training as well. I will talk about training and how it was adapted for pediatric populations.

Along with clear messaging from our medical director who introduced Zero Suicide to critical team leaders across behavioral health and discussed how this effort reflected their current needs and overall mission. We didn't sugar coat the challenges that would be encountered by this or the needs for support. But we did review the various wins that they would see from implementation. These included standard workflows by team, automated and enhanced medical record capabilities, the elimination of duplicated effort. There were a lot of times when assessing risk and including safety plans would have to be completely redone in our current system or our previous system. And that was really something that was improved substantially.

We also knew we could improve staff confidence in risk assessment and safety planning. As Glenn mentioned there was inconsistency across program. Especially working with younger kids, they weren't seeing the same urgency as some of our crisis clinicians. It was really important to see their role in reducing and eliminating gaps in suicide care. We were able to monitor compliance much more easily and increase the use of a common language across all elements.

So these were some things we thought were really important. When you're working with kids, there are also changes, specific programs for individuals with different developmental concerns. We had the opportunity, once we had that common language, to discuss developmental concerns and how each team could provide different workflows and adaptations that fit their needs as well as possible.

Early in the process of training, a decision was made that we needed to provide advanced training to clinical coordinators and supervisors throughout our system to make sure we were covering Zero Suicide basics, increasing buy-in, and making sure that suicide care competencies were evenly understood across different programs. That allowed for feedback and understanding how each team was going to prioritize resources.

We also ended up running small pilot efforts with teams already skilled in suicide care, such as our mood and anxiety program that helped us tweak our training processes and discover pain points for implementation and how they could navigate medical records. So we wanted to start with individuals that were a bit more savvy in this process. That allowed us to roll things out more smoothly.

The training team developed a standardized interactive training. We were able to break that into two 3.5-hour modules with the items seen below. We'll actually go into each of those category. So I won't spend a lot of time here but clearing screening processes, risk assessment, risk and protective factors collaborative safety planning were key elements for that.

All trainings, as mentioned, included a better understanding of core competencies for best practice in suicide care to set the foundation for using tools selected in our Zero Suicide effort. So our trainings included content related to clinician attitude and biases and formed by individuals in lived experience, knowledge about suicide risk, assessment best practices, risk formulation, safety planning, treatment planning, and also an awareness of suicide specific treatments with a strong evidences base as well as legal considerations to make sure our clinicians were engaging in legal and ethical behaviors throughout. And that was drawn in part by the work of SPRC in general. I wanted to give a call out are there.

Each core section including screening, risk assessment and risk categorization were taught using a similar framework. We wanted engagement and buy-in as part of each of our trainings we wanted familiarity with the new processes but also practice. So we first discussed the evidence and the clinical rationale for each tool and then discussed pediatric specific considerations. I'll talk to a few of those in just a second.

We reviewed the instrument in detail while previewing the electronic medical record. It made it a very hands on training as Glenn mentioned with the help of our training and education team.

Our training conducted a role play first. A lot of folks from our suicide prevention team first did role plays and allowed the clinicses to watch how we implemented role plays of varying complexity. Then we allowed the providers themselves to engage in role play and practice documentation in our medical record which is EPIC. Then time was set aside to make sure that they could effectively navigate that tool, including the suicide risk toolkit which we'll be sure to discuss.

So here is that suicide risk toolkit. Again, as Glenn mentioned, this was a really important change for us. We needed to make sure that we had a set of clearly identifiable tools that could be used in a modular fashion so it could really be put into anyone's medical record navigator. As people were trained in Zero Suicide, they would be able to use screening risk assessment and safety planning and categorization tools efficiently.

So we made sure that our training covered this new concept that everyone was going to have access to these tools, and we could

practice reinforcing those toolkit elements. So the training, much like the toolkit itself, could be used in a modular fashion. So some clinical providers did not need training in every single element, but most of our general behavioral health staff did.

Again, this could be inserted into different navigators. So as we expand our efforts into areas like primary care or areas of developmental and behavioral pediatrics, they can take advantage of some of these elements as well over time throughout our hospital system.

So we'll start with the screening tool that was selected, the four to five item ASQ suicide screening questions or the ASQ, which was identified because it has strong psychometric properties and clear suicide specific language. If you kind of look at the items there, you'll see that there's an initial four items. And if any one of those are endorsed yes or no response, then the fifth item, are you having thoughts of killing yourself right now will be prompted and positive screens at that point will relate to a full risk assessment and safety plan.

For more information here, you can check out the NIMH website that has ASQ toolkit information. That's really well developed. So I would use that as a resource. I'm sure that will be in the Zero Suicide resources as well.

Of course, we also wanted to make sure there were some exceptions periodically. So if it was clinically not indicated for that visit, whether it's because of it not being developmentally appropriate, the child physically was not at that visit or there was refusal that did not allow for a valid screen, we wanted clinicses to have some ability to identify those but really train them not to use those unless they were absolutely necessary to use.

So after that, if there were any screens, weighentlied to give clinicians discretion. If there were no change in clinical risk status, for example, there was a historical suicide attempt with no change in the current risk status is being treated successfully, that would not prompt a Columbia to be used in that case. So we did want some natural clinical judgment to be applied when appropriate.

Moving on to risk assessment tool, positive screens on the ASQ prompted the completion of a lifetime recent Columbia suicide rating scale assessment. We chose to use the C-SSRS, very young child cognitively impaired version. This was really selected to support clarity of language, simple language. There's no reason to have multiple documents, even for the teens who could use that tool very effectively. It allowed for really clear documentation and serial assessment.

We did find that the paper version is very dense and our IS team worked hard to remove some of the denseness of the traditional forms, so it actually allowed descriptors of each section to be opened up by the clinician but allowed for pretty seamless, sort of navigation of that tool.

It also allowed for those boxes for the questions for more active ideation, 3, 4, 5 to be prompted with positive responses to

question number 2. So it also -- the medical record does allow for some checks and balances there.

It was really important as we went through this in training to make sure that folks knew to always also assess for suicidal behavior even in the case of negative responses to the ideation. It was important for us to be able to talk through in training that there is some discontinuity, especially with young kids responding to suicide specific questions, that you could be going through this list and there's lots of noes and all of a sudden at a higher level there's a yes or specific suicidal behavior endorsed when that wasn't caught in a previous part of the assessment. So we like to know that some discontinuity is often the real one that behaviors don't always align with the ideation section. We very talk clearly through direct questions and use concrete language with younger kids. This tool has been very effective. It also allowed individuals throughout the system to have a common communication tool. So before, as Glenn mentioned, we had lots of different risk assessment practices, many of them were solid and well grounded, but we really wanted to have the entire system working together so that we could then have repeated assessments and allow for a common language there.

The positive screens also prompted a review of enduring and dynamic risk factors. So we updated our risk and protective factors based on current literature with credit to Christine cha and. We certainly understand the risk factors can't simply be summed up to conceptualize risk I. For each section enduring a dynamic risk factors are provided in a brief summary that can be exported into the clinician's note. This can support clinical decision making as well. That's also part of the -- standard part of the toolkit.

Moving on to safety planning, we then shift to skills involved in collaborative planning in our trainings. Although most clinicians are knowledgeable of safety planning elements prior to training, the process of working with the child and family to identify feasible ways to delay action in a crisis, to regulate intense emotions, to reduce access to lethal means, I will also say we highly encourage and have developed an ability to calm training as well that Julie mentioned before and also to -- we make sure to emphasize how to obtain crisis support from a trusted adult that are very youth supported.

Given our pediatric population we also emphasized the school setting. We made some tweaks. As you can see here for each of our sections, we wanted to make sure that clinicians were thinking about school options. Actually we have separate training now to make sure that we have safety options during the pandemic as well and when school is remote. We certainly want people to be thinking about other settings where youth may be at risk, so how to work with school partners, for example, and very important step of this process was also to make sure that safety plans could be transferred to other parts of the medical record. This is a real short coming previously where we had to go into some of the media tabs and sort of get copies to be sort of redone and rehandwritten. So now safety plans can be

updated by clinicians using existing safety plans that follow the client throughout our system.

So that's certainly a nice addition as well.

And then finally here, consistent with the Joint Commission requirements that Glenn mentioned, clings identify the level of risk for each client with any positive endorsement corresponding to low, moderate, or high risk. Low risk is going to refer to past suicidal ideation or behavior but not within the three months. Moderate is not imminent that can be acted upon in the current setting and high risk is selected when there's active and feasible thoughts of killing once in the current setting. This requires one-on-one constant monitoring. That, again, is something that each of the clinicians can identify.

And then what's really nice at the end of going through this toolkit process, a general summary is provided on the landing page where clinicians can get a brief snapshot of all the risk elements that have been identified previously, and this allows for clinicians who are on the care team to be able to see what the current risk status is, what's been done, what needs to be updated. So that's been a big win as well.

With that, I'm going to turn this back over to Dr. Thomas to talk about some of the data that we've generated.

>> GLENN THOMAS: Because we had taken care to make sure we had discreet data elements we could pull from our EMR build, it was relatively easy to pull data. You can see in spite of the large number of clinicians and patients that with the implementation in July -- and we had a staggered rollout where we completed the rollout in September, we were actually able to get to a relatively high compliance with screening very quickly.

In fact, for the third quarter of 2019 we were just over 95% compliant. We've also looked at then -- sorry. The prior slide was ASQ compliance at first visit. This is follow-up visits. You can see it's slightly lower but still in the 80%.

We also followed up on compliance with the Columbia, if there's been a positive ASQ, there consistently in the upper 70s or 80s. And a little lower for the safety plans. We realized we had some issues with our data that we put a fix in today that makes it more -- makes it easier for your clinicians.

One of the things we're really interested in looking at and are tracking at for this year are the acute positives. That's when a child on the ASQ endorses that they're thinking about killing themselves now. We want to make sure that those kids definitely get a risk assessment and safety plan on the same day. Our goal is 95% for this year. Right now you can see that's where we are with the Columbia and the safety plan. And I apologize that we didn't carry on the data for the second quarter this year. We did see a slight dip with ASQ compliance due to the pandemic and switch to telehealth services.

>> All right. I'll wrap up here. We wanted to wrap up our section today by describing the care and contacts text initiative

inspired by the Zero Suicide institute. Hopefully many of you are familiar with this part. We knew from Workforce Survey and data that transitions in care could be improved at Nationwide Children's Hospital and introducing nondemand caring context is a data informed approach to address this gap.

So in 2018 we obtained funding from SAMHSA, Garrett lee Smith memorial project from the Ohio suicide prevention foundation for texting youth with nondemand after discharge to provide a bridge between in-patient and follow-up care to remind of resources available and validation. One of the high risk periods of time for youth suicide which is just after discharge.

I won't do this background history of caring contacts just in the time allotted. We'll point you to a wonderful article cited in the article by Jason Cherkis about Jerome Motto and his discovery many decades ago that a low effort intervention lead to a reduction in actual suicides. The article discusses modern efforts by researchers and clinicians who does this work to provide client care and highlighting the great work of fellow Zero Suicide faculty member Dr. Ursula whiteside. Additional work with the VA system that texting is feasible and effective. That's a good example of that.

So our inclusion criteria at Nationwide children we set up a basic postdischarge text message criteria to be received by youth over the age of 12 with cell phone access who were seen in acute services. This prompted clinicians to initiate education of the client and family during the discharge process with testings being sent out at regular intervals, one day, 8 days, 15, days 22, 29, two months three month and four months with youth and families who could opt out at any time.

We did not rush the development of this process. We took our time that messaging and image ary in the spirit of nondemand caring contacts. We were not asking them to do anything with this information but hopefully able to experience their validation, support, and connection that were so instrumental in supporting them during their care. We worked with youth and young adults with lived experience going through our in-patient and crisis services to provide feedback on messaging and images. We worked with the IS department to make sure that confidentiality and choice were preserved at all stages. We ended up working with a specific group bandwidth to make sure this was able to be successful. And then in March of this year about a year of doing this manually, we were able to automate the process just like Indiana Jones where he grabs the hat before the pandemic that said we weren't able to do it manually. We fully automated the process. We had carrying contacts going on throughout this entire pandemic period which we were very happy to see.

For all messages here's one, another example of one of our carrying contacts. The goals to validate a range of emotional experience is to remind young people there are these resources and let them know right now in this moment they are enough based on who they are. National and crisis resources are included in each text

despite being automated, they are well received. I know sometimes when you look on list serves people are concerned that automated texts feel like something you're getting from your dentist or it's not something that's meaningful. With young people they've been really well received. We've had some great feedback throughout the process and we're constantly getting updating our images and support.

During piloting, for example, we received this highly memorable text that suggested that universal carrying messages could make a big impact. As you see here, this message that was actually -- it was a photograph taken by our lived experience Zero Suicide committee member and it was just really well received. How do you guys always know when I need you the most. It said earlier these aren't monitored but thanks. Thanks robot thing. It's an authentic teen expression. This is hitting people when they need it most. What's inspiring is that these can be done in a really efficient way and reach lots of kids that we see. We're in a big system and it's gratifying seeing this working so far.

We're always looking to improve our system. Finally at Nationwide Children's Hospital leadership is expanding Zero Suicide across the hospital as part of a larger initiative and positively impacting the overall health of the pediatric population of Franklin County. We're looking forward to expanding our efforts of support of Zero Suicide and learning from other partners across the country such as our next presenters from the Children's Hospital of Philadelphia. Thank you for your time. We're happy to answer questions at the end of this webinar. Thank you.

>> JULIE GRUMET: Thank you so much Glenn and John. What an incredible presentation, a lot of information at once. There is their contact information. You'll have that. We'll get to questions after our next speakers. I'm sure you're like me you're processing all that you just heard. Take a moment. Why don't you type in the Q&A box, maybe one key takeaway from their presentation.

While you're typing, for me, I think one of the things that stood out is how much they trained their clinicians to use these resources. There were role plays. They clearly even that use at the end who responded this is that thing that you told me I would be receiving it. Clearly people were made aware that this was happening. That's critical. That's the difference between dropping in some new practices because they exist in the EHR and making them come alive and make them effective to the staff and the patients. That's how Zero Suicide makes such a difference.

Somebody asked for me to put contact information back up. So I will do that while I'm taking a quick look. I see somebody talking about really liking these text messages. And we do have some -- we did a presentation about this, just like today's presentation. We do a series of public webinars over the last few years we did one about caring contacts. We did a webinar, maybe two months ago about telehealth and youth in particular. So Barbara Stanley was one of our presenters talking about using safety plans for youth and also in settings that are not traditional healthcare systems and how

schools might be able to use them. And all of this is on the Zero Suicide website.

A lot of people something to love the carrying contacts and post cards and the way you used lived experience. I think people are really -- this really is resonating with all of our participants. And I hope people will keep thinking about it. One thing I really want to acknowledge is that the Zero Suicide list serve there are so many great questions, we will have a few minutes for questions after the next set of presenters. This is where we can keep the questions going. Please go ahead and use the list serve if we don't get to your question.

I will move us along and go to the next speakers who are going to have as much mind blowing content as our previous presenters. And the first is Dr. Steven Soffer. He's a licensed psychologist in the Department of Child and at CHOP which is in Philadelphia and co-chief of the division of outpatient behavioral health in DCAPBS. He serves a the training of the psychology internship program at CHOP. He's an associate professor of clinical psychiatry in the Perelman School of Medicine at U pen. He's been there for several years. Jason Lewis is a licensed clinical psychologist and a licensed professional at Penn. The associate director of Department of Child and adolescent psychiatry and behavioral sciences at CHOP, the associate director of the internship program at CHOP and also one of the leading members of the Zero Suicide initiative there. They've been doing Zero Suicide there for several years and are really one of our go-to resources to really learn more about children and youth. We're appreciative to have them join us today. I'll turn it over to you Steve, and Jason.

>> STEPHEN SOFFER: Great, thank you, Julie, and thank you to doctors Ackerman and Thomas for the great work you shared with us today. It's a pleasure to be here for this webinar today and thank you for inviting us to do so.

So our agenda today is we're going to give some background to two of our primary initiatives through our Zero Suicide journey so far. One is to talk about the our standardization of our suicide risk assessment practices through using the C-SSRS in our electronic health record.

The second is development of a clinical pathway guiding clings in using best practice suicide risk assessment and intervention strategies specifically for child and adolescent population.

Before I go into these initiatives, I want to give a little bit of background about Children's Hospital of Philadelphia, also known as CHOP. It's a 546 bed hospital which receives approximately 30,000 in-patient admissions and 1 hadn't 4 million outpatients visits per year. A care network in Pennsylvania and New Jersey and serves as a community hospital and primary care center for the immediate supporting community and across the Delaware valley which serves an estimated population of about 10 million people.

Dr. Lewis and I are both psychologists in the Department of Child and adolescent psychiatry and behavioral sciences which a

multidisciplinary department which consists of psychologists, psychiatrists, clinical social workers and psychiatric nurse practitioners. Our clinicians practice throughout the hospital and through multiple ambulatory locations including primary care often as members of integrated interdisciplinary care teams.

We started our Zero Suicide journey in June 2015 when we attended a Zero Suicide Academy. This was a very important experience to our group, to our team in learning the Zero Suicide model and the strategies that have continued to support our quality improvement work for the past five years.

To date our primary areas of focus have been the Zero Suicide elements of lead, train, identify, and engage. We'll present you some information about how we've been doing during this presentation this afternoon.

We've also been very fortunate to have the support throughout this of our department chair, Dr. Tommy Benton who has inspired and supported us throughout our journey and has supported us also in getting connected with other areas of our institution which is our overall goal, of course, which is to support the entire health system, including our Department of Child and adolescent industry.

The slide that you are looking at now is summarizing some of the results from one of our first initiatives which was to ask our colleagues to complete a Zero Suicide Workforce Survey. This was done in order to get a baseline understanding of where our clinical colleagues stand with their training, their backgrounds, their practices, as well as their comfort with doing -- engaging in suicide risk assessment and care for patients at risk for suicide.

I want to point your attention to the line at the bottom where it really caught our eye that a good number of our colleagues really expressed dissatisfaction about the existing processes for our suicide risk assessment and safety planning and caring for our patients at risk for suicide. Additionally 67% of respondents to our sway desired more formal screening and assessment practices.

So this really highlighted the need for our two initiatives that we'll talk about today. One is the implementation of standardized suicide risk assessment practices and the second is a development of care pathway for those at risk for suicide at guidance for clinicsor clinicians in how to provide care to a patient once they're identified as having risk.

The other thing we took from this survey as well as some of our other baseline interviewing was the development of our four key drivers which have become the organizational focus of our Zero Suicide work. These include focusing on clinician's skill, clinician knowledge, communication among clinicians, and timeliness. Hopefully you'll see us touch on those as we go through those initiatives this afternoon.

So we're first going to talk about our efforts to standardize our suicide risk assessment processes using the Columbia suicide severity rating scale. Through our needs assessment during the initial stages, one of the things we focused and realized there is

significant variability in the process and communication of suicide risk assessment among our clinical teams. We recognize that this variability in care could result in incomplete or inaccurate assessment as well as limitations on how risk assessment results are communicated across clinicians, care teams, as well as with patients or their caregivers. And the responsiveness of our treatment planning and the level of risk.

Therefore we embarked on an initiative to develop a standardized risk assessment approach with goals of improving identification of high risk patients relative to clinical interview which was the standard of care at the time. Increasing reliability of our risk assessment across time and clinicians, facilitating improvements in inner clinician communications about a patient's risk status, helping our clinicians target intervention efforts that are responsive to a patient's identified risk, also supporting the assessment of -- supporting the ongoing assessment of recurring patients or returning for care particularly in ambulatory settings once we have a baseline and supporting our institution and meeting Joint Commission standards and national patient goals for suicide risk screening and assessment.

So after researching some assessment instruments and doing benchmarking like our colleagues at Nationwide we selected the Columbia suicide severity rating scale, Columbia is well known and established. It has some advantages in that it doesn't require specific mental health training to utilize and as Dr. Ackerman and Thomas mentioned it has versions applicable to children and adolescents. We are also using the pediatric versions of the lifetime for our new patient visits and less contact pediatric for follow-up visits for established patients.

Additionally it's a semistructured interview that really supports using specific definitions of suicide ideation and behaviors which we thought was really important for addressing our needs of improving the reliability of our assessment as well as communication of assessment results.

So our implementation of the C-SSRS in our EPIC medical record occurred in two phases. Phase 1 was training where we developed a staff training module that integrated didactics practice vignettes, case-based discussion, as well as a walk through about how to use the C-SSRS in our EPIC patient care flow.

To date, since October of 2016, we have implemented this training with over 300 clinicians, clinical trainees, and social workers. In fact, Dr. Lewis and I as well as one of our colleagues, just completed our annual training session for all of our new trainees that come into our department across all disciplines to whom we provide training.

We also developed a short prepost test assessment that asks some knowledge questions as well as the participant's comfort and their perceptions of their ability to assess suicide risk and they received the training to engage in suicide risk assessment. I've seen some nice increases in that through this training.

Our second step was integrated the C-SSRS in our EPIC electronic medical record flow. We made this as a required element to close all of our patient care encounters. I'll talk a little more about that as we move forward.

We also developed a documentation form in EPIC for associated risk and protective factors, which I think you'll see is fairly similar to the form that Dr. Ackerman showed us a little bit earlier. In addition we developed something called the best practice advisory through the EPIC EMR that prompts clinicians to add suicide specific problems to the EPIC problem list depending on the responses to the C-SSRS. We've implemented the use of C-SSRS across the entire department as well as psychiatric or behavioral health here at CHOP.

So this slide just shows you a quick screenshot of the new patient -- what a clinician will see when they do a new patient visit. It is an EPIC version of the C-SSRS lifetime version for pediatric patient. Our implementation files all the Columbia administration instructions. This is a lifetime -- as I said this is the lifetime version we use for new patient visits. This is a required element to have this completed. A clinician wouldn't be able to finish their documentation without completing this.

Also, you'll see items 3, 4, and 5 are populated on the screen, but they would not come up unless there's an endorsement of items 1 and or 2 on the Columbia -- following the Columbia administration instructions.

This next slide shows you the mockup of the screenshot of a Columbia since last contact version which we used for follow-up visits for established patients. Clinician would be asked to complete this in response to a positive screen. So our process is that for an established with a pre-existing Columbia they would do a screening. If there's a positive screening, then the Columbia would get populated and completed for that patient care visit for established patients.

This is the risk assessment form that I referenced before. This is a nice place that we've included for clings to document risk and prortective factors that are unique to an individual patient. This is developed based on a similar assessment form that accompanies the C-SSRS and we did a literature review that are relevant to child and adolescent populations. This in essence functionor functions a database that follows the patient through the care and can be followed by any member of the care team at any time. If they're receiving care from more than one clinicians, any clinician can populate something new or take something off depending on the progress of the treatment or how elements may change.

This slide shows a screenshot of the best practice advisory. Again, this best practice advisory also called a BPA is something that would pop up on the screen based on the clinician endorsing certain items. So if a clinician endorses certain items for severity for suicidal ideation or behavior, one or more of these best practice advisories would pop up, and the clinician can add the problem to the problem list as well as add details to the problem using a little

hyperlink that says edit detail. We thought this was a really beneficial component of using the Columbia in the medical record because it provides an opportunity to communicate across clinical teams about a patient's level of risk, which is particularly important in our setting where patients may travel across different departments to receive their care.

One of the other really nice elements of using the C-SSRS in our EPIC medical record is it yields a lot of data similar to our colleagues at Nationwide children's that we're able to review for quality and improvement purposes. Prior to implementing the C-SSRS we did a review to capture baseline data of patients that had been seen between July and October of 2016 for new patient visits and we manually review their charts and coded the documentation according to the C-SSRS definitions for suicidal ideation and behavior. We did that for 395 patients and included those to include an all patient sample which I'll show you in a moment with over 4,000 new patient visits with a mean patient age of 11 and a half years with 230 patients under the age of 6. We also found that our compliance with completing the C-SSRS for new patient visits is close to 100% which isn't surprising necessarily because we basically have something called a hard stop that the clinician can't complete their documentation until they complete the Columbia.

I included some stuff on the slide that is basically up to date we have almost 23,000 patients have a C-SSRS completed and the number of patients that -- a new patient lifetime version or follow-up since last contact version and over 122,000 visits have some kind of Columbia completed for them.

So just shifting to our data, our outcome metrics for our data are looking at the percent of patients identified as having a type of suicidal ideation for purposes of today's presentation which is wish to be dead and number two nonspecific suicidal thoughts. The next is suicidal behavior and look at actual suicide attempts and aborted suicide attempts. And then the rate of having a suicide item on the EPIC problem list.

So on this slide, if you look to the left, you'll see our baseline data prior to November 2016 and our implementation of the C-SSRS in the EPIC electronic health record starting in November 2016. You can see an increase in the rates of identification of patients that are reporting or wish to be dead in their lifetime after a new patient visit and or a suicidal ideation at that point as well.

This next slide shows similar data for rates of actual attempts and aborted attempts which are two of the suicide behavior or attempt items on the C-SSRS. Again, to the right is our baseline, and then from November on you can see increases in rates of identification of both actual attempt which is is the blue line and aborted attempts which is the orange line.

I just want to point out for both these slides, our interpretation of these data is not that we started to see a more acute patient population and that's what we're picking up on. Really

what we're picking up on is that by using a structured assessment measure and doing a structured process we are doing a better job of picking up on suicide risk factors than we were prior to this implementation.

And this last slide is just looking at the rate of clinician adding a suicide item on to the EPIC problem list in response to that best practice alert. So you can see prior to November 2016, that was happening very, very rarely. Since then, we're probably a mean around 6% of the time clinicians are adding this to the problem list. Again, this is really important because this is a way through the medical record that we can communicate with other clinicians, including outside of behavioral health about a patient's suicide risk status.

With that, I'm going to hand things off to Dr. Lewis who will talk to you about our clinical pathway development.

>> JASON LEWIS: Thank you, Dr. Soffer, I appreciate that. So, yes, now we're going to switch gears a little bit. And I'm going to talk about the development of a suicide care pathway here at CHOP. This is something that we're really excited to talk about today. It's not only a resource for clinicians here at CHOP, but it is publicly published on the CHOP website. It can be accessed by the Zero Suicide website. It's a resource for clinicians across the country and throughout the world. We're excited to talk about it today.

The first, I guess, question to ask is what is a clinical pathway. For a little background about clinical pathways, really they're mental models used by clinicians at the point of care to facilitate the deliver of high quality medical care. They really have two broad aims. The first is to standardize care and the second is to provide guidance to clinicians.

Earlier Dr. Soffer presented some of the results of our Workforce Survey. If you remember, there was a desire for improved processes related to suicide care as well as increased support for clinicians treating youths at risk for suicide. Our clinicians were looking for improved ways of treating -- assessing and treating youth with suicide concerns and really for support in being able to do so effectively. So we decided at that point, looking at the data from the Workforce Survey, that a clinical pathway could contribute to both of these points.

So our first step in this process was to do some benchmarking in existing care plans related to suicide care.

What you see here on this slide are a few examples. So the VA has a center of excellence related to suicide prevention. They've published a fantastic risk management stratification table that focuses on risk. What we found that was really interesting about their pathway was the focus on acute versus chronic risk. Certainly we focus a lot on high, intermediate, and low risk. They were pointing out that there's an additional dimension to think about, this acute versus chronic risk. You can have someone that has high chronic risk, but then another person who has high acute risk and

what you do for those two people might be different.

Certainly with children and adolescents chronic risk looks very different than it does with adults. But we do want to think about those kids and adolescents who are more acutely at risk versus concerning risk factors that have happened several years before.

We also looked at both center stone and Institute for Family Health have comprehensive suicide care pathways which emphasize the importance of thinking about the entire process, starting from screening, working through assessments, and continuing through intervention. So sort of the takeaway from looking at those two examples was the importance of the pathway being comprehensive and covering each step of this process.

We also looked at a lot of the work coming out of Marsha linen and her group that was on the importance of risk assessment. We knew that we really wanted to spend a lot of time in our pathway thinking about risk and protective factors and red flags and all the other factors that play into risk formulation besides the suicidal inquiry.

Although one of the -- I think one of the most significant takeaways when we were doing our benchmarking was really the lack of clinical pathways specifically focused on the youth population. A lot of the pathways that are developed that have been developed were more focused on adults. And so we really saw a need for having a resource for clinicians that work with children and adolescents.

So specifically when we were thinking about developing this clinical pathway for children and adolescents, so this was 2017, we did our research. We decided to put together the pathway. We were thinking specifically about what the pathway would do for us, so building off the general goals of clinical pathways, we had a few specific goals that we wanted to accomplish. One we wanted to increase the reliability of the identification of suicidal ideation and behavior through screening. We also wanted to provide guidance and support to clinicians to complete a full suicide risk assessment by integrating both the presence of suicidal ideation and behavior as well as risk and protective factors.

We also wanted to provide guidance to clinicians as to the appropriate and intermediate and ongoing plans of care. As I mentioned before, having guidance was something that the Workforce Survey revealed, that clinicians were really wanting to have support.

Lastly, we also recognized the way that a pathway could support documentation and enhance communication among clinical teams. We have lots of providers. We have kids that see multiple providers. And we wanted to make sure that what I was picking up and deciding upon can easily get communicated to any other providers that was working with that particular patient.

So next, I'm showing here is a timeline of the development of the pathway. So as you can see, this was a lengthy process. Start to finish it took a little over two years. The team that developed this pathway was our Zero Suicide team at the time. The team has since grown, but at the time it was Dr. Soffer, myself, and a third member, Dr. Lawrence, who is a psychiatrist here at CHOP.

Throughout this process we had a lot of support from the clinical pathways team at CHOP. Fortunately CHOP has a department here that supports clinical teams and putting together pathways.

So we submitted the proposal in April of 2017. It was accepted in July 2018. At which point we began working on it. So from that point on, for the next 11 months, at a minimum we were working every other week for about an hour. If I remember correctly, we got up to -- I think it was version 19 of a draft.

In June 2019 we finally were satisfied with the product. As I mentioned before, it was published online. On the bottom of the slide there you can see the URL for the pathway. You can also just Google CHOP suicide pathway and probably get to it as well as I mentioned before it's -- there's a link to it from the Zero Suicide website.

So here are some screenshots of the actual pathway. So the overall pathway works in a linear fashion going from top to bottom. It progresses from screening through the suicidal inquiry to assessing risk and protective factors to risk formulation, and then ending with care plan considerations. This first screen has sort of the top half going through the suicidal inquiry and risk and protective factors. 6.

On the sides in blue boxes are additional resources for clinician such as patient education materials, articles about the C-SSRS, articles about safety planning, information about partials and intensive outpatient programs specifically for clinicians in the Delaware valley here in Pennsylvania, New Jersey, and Delaware. The way that the pathway works is that the front page is really high-level guidance. Then all of the blue font are hyperlinks to back page content where there is more detailed specific information basically it starts off with when and how to screen. If the screen is positive, then there's guidance as to how to complete the suicidal inquiry using the Columbia. Depending on results of the inquiry, an individual is put in one of three brackets, low, medium, or high. You can see green, yellow, and pinkish color. The pathway spells out on the Columbia would lead to what level of acuity. Depending on what the results are of that Columbia you can put the kid in one of these acuity buckets.

Clinicians then walk through the process of gathering risk and protective factors and then using all that information, the suicidal inquiry, risk and protective factors, red flags, which are very specific acute risk factors, the clinician is guided through the risk formulation process.

Then based on that risk formulation there's recommended care plan considerations. For each suicidal inquiry level, low intermediate, or high, there's both standard care plan considerations and enhanced care plan considerations. That allows the clinician to take into account the risk formulation and your own clinician judgment.

Next I'm going to show some screenshots of some of the back page content. So on the left is information about the pathway, its

purpose, sort of when you should screen an individual for suicide. On the right is some of the back page content about the Columbia itself. As you can see, there's hyperlinks that take you to the versions of the Columbia that we use as Dr. Soffer mentioned earlier. There's also a link to the home page of the Columbia. So when you're dealing this pathway, you have all the resources right there at your fingertips.

Here's back page content related to risk and protective factors. We describe what risk and protective factors are. We break up the different factors in different domains. In the screenshots you can see two of the domains, the clinical and psychological, but there's also demographic, family and social domain, as well as an environmental domain. For each of those domains we list out risk and protective factors factors that are things that you should be assessing.

One of the helpful features we put in case examples in each of the acuity levels. Here on the screen we have the intermediate acuity case example. The purpose of this is really to provide guidance as to when you want to think about standard care versus enhanced care. Here you can see Brandon and Tommy. And they have the same results on their Columbia. So they're reporting the same history of suicidal ideation and behavior, but the risk and protective factors factors different which would lead to Tommy needing or benefitting from enhanced care. So it's really a helpful way to kind of determine when do I need to sort of up what the individual's going to get?

So lastly, there's two screenshots here on the left is back page content related to interventions. So we provide a description of all the different interventions that we list on the pathway that we recommend at the various different acuity levels.

On the right is a listing of some of the patient education materials that you can access through the pathway. As you can see, all the links take you to either a PDF or some other document that you can print out and give to families.

All right. So thank you. So on behalf of the CHOP Zero Suicide team and myself and Dr. Soffer, we would like to thank everybody for tuning in today. If you're interested in finding out more about what we do at CHOP related to suicide prevention, there's a link that can get you there. And if you want to have access to the pathway, like I said, you can find it through the link there. You can also find it on the Zero Suicide page. It has a reference to it as well.

And now I'm going to turn things over to Julie.

>> JULIE GRUMET: Thank you so much, Jason and Steve, and all of our presenters, such great information. It really resonates for me. What does that mean -- pathway. Now is it every other week, 19 versions. I think it's great to think about that you had help from within your hospital, and it was outside of behavioral health and outside of suicide prevention. So really a lot of food for thought. But there were processes in place that helped people to

do this hard work.

So-so many moments in both of your presentations about things to take away that I think could be embedded in work that all of you are doing.

So what resonates for you? Let's take a moment. Type in a few takeaways. What's standing out for people?

I see people talking about really liking the standard and enhanced options for clinicians. It sounds like people are even curious about using EPIC and the Columbia. I'm going to take a couple of questions about that in a moment. But I certainly know that this is something that you can contact EPIC about. They are familiar with Zero Suicide. They have a lot of these processes already built in. But there are questions that you have to ask locally your IT people to help you with to contact EPIC to embed these.

I'm going to move us into the Q&A. You can keep commenting here about some of the information and key takeaways you're seeing. I think it's great. Hopefully it stimulates other people in their key takeaways. Thinking about the level of care, chronic versus acute suicide, I think that's another important key takeaway. Certainly a lot of systems encounter that but not necessarily think about what they're going to do in that case. So really love the attention to that.

In the meantime, are there particular questions for our presenters? I'll open it up across all four presenters now. Unfortunately we're not going to be able to get to everything today, but we have the list serve and we'll take a look at the questions afterwards and see if there are things that we can post afterwards.

In particular, I know both hospitals use the ASQ and the Columbia. I'm going to turn the first question, though, over about why -- I think I'll turn this to, I think, John may be the best suited to kick this off. Question about whether the ASQ is (Audio breaking up).

>> JOHN ACKERMAN: Sure. Hopefully you can hear the audio and it's not breaking up. Our selection around the ASQ as our screening tool and then the Columbia suicide severity rating scale was done primarily based on decisions around language comprehension, directness, and the validity of psychometric properties of the ASQ done in the emergency room with youth and feasibility in outpatient setting. It has a really good track record of being accessible, understandable, and allows for clear decision making processes to move on to a risk assessment or not. It doesn't mean that no clinical insight is necessary to make those decisions.

Like you said, there are times where a risk assessment might not be clinically indicated so we want to empower staff to make those decisions. It made a lot of sense for us to use that tool. I know some use Columbia as a screener and follow up as needed. I think there are many ways to think through what's best for your system. The Columbia made a lot of sense from a medical record and documentation standpoint for us. Many of our clinicians were already trained in the case support, for example. Many folks also

were aware of the BSSA part of the ASQ which is the risk assessment that follows up ASQ positive screens. Really it was just getting a sense of all the different programs that we have, what were folks comfort level and what would allow for a medical record be flexible in meeting the needs in a serial sort of way. That was, again, like Drs. Soffer and Lewis were able to track efforts over time. Those were the best tools to meet those needs. Not necessarily a perfect one size fits all selection but I think it did help us in the long-run.

>> JULIE GRUMET: Thanks. Do you want to add anything, Steve, about how you chose the ASQ and the Columbia and how these worked together?

>> STEPHEN SOFFER: Yeah. Actually we don't utilize the ASQ in our behavioral health practices. It is used in our emergency department as a screening measure to determine if a further assessment needs to be completed. But in our behavioral health practices throughout our department as well as our integrated behavioral health clinicians in other medical divisions, for a new patient visit we just -- we assume, if you will, that the patient is potentially at risk because they're coming for a behavioral health visit. For new time visits we have a lifetime Columbia completed for that patient.

Once that's done for any patient, then for an existing patient who's coming back for a follow-up visit, then we have some screening questions that are in our medical record that prompt the clinician to do a screening. If there's a positive, then they do a since last contact version of the pediatric Columbia. So that's the process that we set up.

We certainly considered using the ASQ as a screening measure. But I think as Dr. Ackerman said, I think it was a consideration of our various programs and practices and what we thought would fit best across programs to have something that was going to be consistent. That's just a direction that we went in that we thought would work best.

>> JULIE GRUMET: I think that makes a lot of sense. Certainly what we here is a lot people getting paralyzed in making the perfect decision. I think the motto of not having the perfect be the enemy of the good really applies here so long as you're making a thoughtful decision based in evidence rationale and you're going to train your staff to use it. I think those decisions clearly were the right decisions for each of your agencies. We do get people who feel sort of stuck that it has to be the perfect decision, which gets me to another question. And I think I'll send this one to Jason, because people are asking about, how often do you review your clinical pathway? How often do you update it? I think that idea, once set these different procedures that you choose to do, which screening tool, how often you'll administer it, the design of the clinical pathways, can you say a little bit about how you keep those fresh up to date and routinely take a look at them?

>> JASON LEWIS: Sure. Absolutely. Thanks. So I guess it's done in a couple different ways. So fortunately having the support

of a pathways team at CHOP, they are constantly monitoring the pathway, making sure the links are active, making sure that everything works. So certainly that piece needs to happen because any time you have something live with links, you want to make sure that everything is working. In terms of the clinical piece, we're constantly sort of looking at it, think thinking about what needs to be added. For example, the whole piece about adding information about getting medical assistance for families and putting in specific resources for higher levels of care, whether it be partials or IOP. That was an addition we just made a couple of months ago. We're routinely looking at it and routinely thinking about how to add it and how to update it.

We have -- we're constantly on the list serve and looking at different things. So as sort of processes change, as recommendations change, we're instantaneously trying to make changes to the pathways as well.

>> JULIE GRUMET: Great. What about from Nationwide. Glenn, how do you examine how well carrying contacts are working how you update your practices or training? How do you go about that?

>> GLENN THOMAS: With regard to the screening and assessment safety planning, just by looking at our data and finding anomalies, we've been able to identify where we might have confusing elements for staff. We've also added -- John can probably speak more to this, hard stops in some of our processes in the suicide toolkit.

At this point, though, we've really been in the game less -- almost a year. So we've made updates to our carrying contacts we've added content. Specifically with regard to carrying contacts, we're approaching our thousandth patient who has received the series of texts which is a nice time to stop. We'll go back and compare readmission rates, return visits to the psychiatric crisis department, services like that, comparing kids who got the texts and those who didn't. We have not made a lot of changes.

I also just want to comment on the sophistication of CHOP's suicide pathway. I think there's a lot we can learn about how we can improve our services here as we do that.

>> JULIE GRUMET: Yeah. I certainly thank you so much. And I think that's such an important observation but also to recognize, for both of your hospital systems, you have to start somewhere, clearly you've made some decisions, and you're going to take good continuing quality improvement make changes in realtime and yet you're all in and have the data to show to track your next steps. Regulate both of your healthcare systems are doing incredible work to only be a year in and have this type of data and perspective. I know CHOP, you've been doing this a little bit longer. You're such leaders in the field. We're so appreciative to have had your time in today's webinar. It was really a lot to learn and a lot to digest.

I just want to thank all of our presenters, Glenn, John, Steve, and Jason, as well as our tech team, Keri, and La Sean, and Adam and Caitlin for putting this together. Thank you for joining us. We're at 4:30. I hope everybody has a lovely afternoon, a good summer.

And this will be up on the Zero Suicide website as a recording within the next week or so. So take care, everybody. Thanks so much. And be well.

