NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

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Zero Suicide Breakthrough Series: Outcomes and Recommendations

September 2015

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Contents

EXECUTIVE SUMMARY

Launched in 2010 by the U.S. Secretaries of Health and Human Services and Defense, the National Action Alliance for Suicide Prevention (Action Alliance) envisions a nation free from the tragic event of suicide with a goal of saving 20,000 lives in five years. The Action Alliance is the public-private partnership advancing the National Strategy for Suicide Prevention (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. Its organizational support is provided by the Suicide Prevention Resource Center (SPRC).

A key concept of the NSSP and priority of the Action Alliance is Zero Suicide, a framework for approaching suicide care that is rooted in seven essential elements that range from leadership-driven culture to data-driven quality improvement. In late 2014 the SPRC, in partnership with the National Council for Behavioral Health (National Council), sought applicants currently implementing the Zero Suicide approach from around the country to join a Breakthrough Series intended to provide individual and group coaching to help provider organizations and state systems accelerate Zero Suicide implementation.

Ultimately, the purpose of this initiative was two-fold: first, to advance implementation of Zero Suicide and learn effective and viable state-level actions to support implementation and second, to identify provider-level actions and protocols that facilitate successful improvements in suicide care and adoption of the Zero Suicide approach.

Each team included a state-level governmental agency (the lead applicant) and a provider; six teams were selected to participate. The Breakthrough Series ran from December 2014 through September 2015 and consisted of monthly group webinars, bi-monthly individual team coaching, and regular data submissions for quality improvement purposes.

The quantitative and qualitative data collected during the Breakthrough Series resulted in the following lessons learned in accelerating adoption of suicide safer care:

- State leadership is critical.
- System- and organizational-level data are catalyzing.
- Ongoing implementation supports build and maintains momentum.
- Workforce needs additional training to adequately implement this approach and supervision to support the changes in practice.
- Need for balance between mandate and guidance.
- Managed Care Organizations and other financing policies can create barriers to Zero Suicide implementation.
- Culture change takes time.

Based on these lessons learned, the following recommendations are made for State Executive Bodies, Federal Executive Bodies, and SPRC.

Recommendations for State Executive Bodies:

- Recognize that in order for change to happen there needs to be focused planning and attention from the state-level with clarity of direction and rapid movement to create buy-in from a small part of the provider community that can be built on in the future.
- Partner with providers who have the capacity and leadership to stay focused—these providers will prove to be vocal champions.
- Seek dynamic leaders from the survivor community who can partner and advise in the full adoption of the Zero Suicide approach.
- Adopt payment policies that support the Zero Suicide approach, including: adoption of Electronic Health Records, incorporation of Zero Suicide principles into state managed care contracts, and payment for care transition supports.
- Partner with other health, education, and justice entities at the state-level.

Recommendations for Federal Executive Bodies:

- Extend Medicare and Medicaid reimbursement for meaningful use of Electronic Health Records to behavioral health providers and entities.
- Support additional Zero Suicide Breakthrough Series'.

Recommendations for SPRC:

- Provide in-depth training and technical assistance to states ready to engage in intensive efforts related to implementation and use of data to drive organizational change.
- Develop a Zero Suicide Academy toolkit for states to run their own Academies.
- Engage the Health Resources and Services Administration and the National Association of Community Health Centers to explore ways to infuse Zero Suicide approaches into the primary care safety net.
- Conduct outreach to Managed Care Organizations to inform them about the Zero Suicide approach to care and prevention.

The remainder of this report details the various tactics that were utilized as part of the Breakthrough Series to encourage and support organizational change and implementation of the Zero Suicide approach.

INTRODUCTION

In late 2014, six states and their provider partners set out, in partnership with the Suicide Prevention Resource Center (SPRC) and the National Council for Behavioral Health (National Council) on the *Zero Suicide Breakthrough Series* (Breakthrough Series) – a project designed to learn how best to support the successful launch and implementation of the Zero Suicide approach under the direction of a state mental health or public health office. State leaders who had already begun the process of launching Zero Suicide initiatives were asked to invite a provider organization to partner with them in the process, and over the course of the Breakthrough Series' nine-month period, were given additional technical assistance and supports to move towards suicide safer care practices.

An intentional and valuable facet of the Breakthrough Series was that teams included both state-level leadership charged with advancing Zero Suicide and provider-level organizations. Successful innovation in behavioral health requires dedicated, pioneering providers, but for complex change that requires stepping outside of existing operational and financial policy norms, attention and support at the state-level is undoubtedly ***essential*** for success.

"Zero Suicide" is often referred to as an aspirational goal; it is also a new, evolving toolkit for improving "suicide care" in health care and behavioral health care organizations. The approach is based on the 2011 Suicide Care in Systems Framework report produced by the Clinical Care Task Force of the National Action Alliance for Suicide Prevention. With the guidance of the Task Force and its successor Zero Suicide Advisory Group, SPRC developed an online toolkit for organizations implementing the Zero Suicide approach (accessible at www.zerosuicide.com). To date, there is no mandate for health care organizations to improve suicide care, and in most cases, additional funding is not available. The Breakthrough Series was intended to help further embed the model into existing health care systems, to develop and test this approach to replicate innovation, and model a data-informed approach to facilitate more effective implementation and evaluation.

While the goal of zero suicides is visionary, the Breakthrough Series demonstrated that implementation of the practices outlined in the Zero Suicide toolkit help to not only prevent suicides, but also to bring organizations implementing the approach in closer alignment with other changes occurring in the U.S. health care system. The Zero Suicide approach is a population health-based approach; organizations must look at the overall patterns of suicide risk within their organization and their communities. They analyze the service patterns of people who die by suicide, they work at stratification of risk, and then they develop screening and assessment processes that lead to clinical pathways that give them decision support. These components are essential to prevent suicide among people in care, but they are also key to becoming a high performing organization prepared to use data and quality improvement to move forward in the emerging health care system.

Data elements for the Zero Suicide approach had previously been developed but not systematically applied. The Breakthrough Series elevated use of data as a key component of the model. From population based data (e.g., deaths by suicide), providers moved to organizational level data that reflected the implementation of screening processes within their own clinics. Were people screened

for suicidal thoughts, for past suicide attempts, for the symptoms that we now know make death by suicide more likely? The organization then set up assessment processes using evidence-based screening tools known to identify suicide risk. The process of moving from screening to assessment was analyzed to see what the potential barriers were to receiving the highest level of suicide safe care.

Looking at provider level data with this level of specificity was new for some of the providers (as it is relatively new across the behavioral health care system). As the process continued, providers and their state partners learned to use the data to ask questions, to identify key barriers, and to develop strategies to address those barriers and improve the care provided. Organizations implemented principles of Rapid Cycle Change in responding to the data that was made available to them. Becoming data driven at this level is a key component of becoming a high performing provider organization.

While the focus of the Zero Suicide approach is on reducing the number of deaths by suicide, the Breakthrough Series demonstrates implementation of these practices (evidence-based tools *plus* measurement *plus* rapid cycle improvement) has an impact on all the services within an organization and improves the total overall quality of care — another marker of a high performing organization poised to move into the future of health care with greater success.

Can we really get to a place where there are no suicides? Some of the teams in the Breakthrough Series and others who have implemented the Zero Suicide approach have experienced months and even a year without a death by suicide. These organizations report that they are continually refining their processes, policies, training, and approaches to care to expand the length of time between deaths by suicide. Their process and progress is outlined in this report. Data collected through the Breakthrough Series is also analyzed. Recommendations for states, governmental agencies, and provider organizations are summarized to support and guide the future development of Zero Suicide initiatives.

SECTION 1: BREAKTHROUGH SERIES GOALS, ACTIVITIES, AND PARTICIPANTS

Breakthrough Series Goals

The vision of the Breakthrough Series was to determine how to best support the successful launch and implementation of Zero Suicide under the direction of a state mental health or public health office. This vision was broken down into short, medium, and long-term goals. (See Appendix A for the initiative's logic model.) Data about progress towards reaching the short and medium-term goals were collected through bi-monthly report submissions, coaching calls, and webinars. The short and medium-term goals were met. Participating organizations were given tools and technical assistance to independently meet their long-terms goals, but information on meeting these goals is outside of the scope of the Breakthrough Series. The long-term goals continue to be future targets as a nine month Breakthrough Series is not enough time to measure and achieve this level of organizational change.

Short-term goals

- Improved scores on Zero Suicide domains on the Organizational Self-Study. As shown in the qualitative data elements section of this report, participating organizations improved on the Organizational Self-Study.
- Increased rate of screening for suicide risk. Each participating organization either started using screening tools or increased the population screened during the series. As detailed in Figure 1, all participants also improved tracking of screening rates. The reliability of the data at the start of the Breakthrough Series makes it difficult to determine the level of improvement in screening rate during the Breakthrough Series.
- Increased rate of assessment following positive screen for elevated suicide risk. As discussed after Figure 2, all participating organizations either reached 100 percent assessment rate, improved their assessment rate, or improved tracking of this metric during the Breakthrough Series.
- Increased training on best practices in any or all of the following areas; the need for training was described in the Organizational Self-Study tool, work plans, and bi-monthly reports. Training was provided by Breakthrough Series faculty during coaching calls, the mid-year face-to-face meeting and monthly webinars, as discussed in the Breakthrough Series Activities section of this report. In addition, participating organizations reported on their bi-monthly reports that they provided training to staff members in the following areas of clinical care:
    - Treatment
    - Engagement
    - Safety planning
    - Means restriction
    - Warning signs
- Capacity for providers to report on the number of suicide deaths in population or develop a plan to do so. Developing the capacity to track suicide deaths was the largest barrier to properly tracking the Zero Suicide approach's metrics. Through coaching during the Breakthrough Series, participants were able to improve tracking at the provider and state-level.

Medium-term goals

- Build policies and protocols for embedding suicide care practices at the provider and state-level. All participating organizations were able to provide examples of policies and protocols upon completion of the Breakthrough Series. These items were discussed during the final webinar.
- Development of team-based and overall lessons learned document. A lessons learned document was developed upon conclusion of the series.
- Build supports to sustain implementation of the Zero Suicide approach. Each participating organization reported that they were able to build supports in the form of staff dedicated to advancing Zero Suicide activities, staff training and other quality improvement initiatives, and/or institutionalization of new policies.

Long-term goals

- Reduction in suicide attempts or re-attempts.

- Zero suicides.
- Reduced costs to the health care system due to reduced hospitalizations and re-hospitalizations.

Breakthrough Series Activities

The Breakthrough Series used several different strategies to accelerate adoption of suicide safer care practices and policies. Technical assistance was delivered through questionnaires, organizational self-studies, webinars, bi-monthly coaching calls with expert faculty, an in-person meeting and other elements. All technical assistance was delivered within the context of a Rapid Cycle Change approach which required teams to use data to inform their planning, and rapidly engage in course correction as needed. These elements were all designed to support states and providers in operationalizing the Zero Suicide approach to suicide safer care. The specific elements of the Breakthrough Series included:

- **Application**: State agencies were the "lead applicants" in order to assure that there was state-level buy-in to engage in conversations about system-wide issues related to implementation of suicide safer care. The Breakthrough Series application was developed and structured to ensure that organizations accepted into the program were aware of the program expectations, while also processing the internal service structures to effectively work towards implementation of the seven essential dimensions necessary for health systems to have a comprehensive approach to suicide prevention. The seven dimensions were based on the Action Alliance's Clinical Care and Intervention Task Force, *Suicide Care in Systems Framework*. More information on the selection process can be found in the next subsection.
- **Organizational Self-Study**: The Zero Suicide Organizational Self-Study tool was used in the Breakthrough Series. It is a questionnaire that challenged states and providers to assess the adequacy of current suicide care protocols and consider their internal ability to withstand and facilitate the changes necessary to implement the Zero Suicide approach. More specifically, the self-study requires organizations to account for their organizational cultural and practices around the following Zero Suicide dimensions: developing a leadership-driven, safety-oriented culture; suicide attempt and loss survivors in leadership and planning roles; systematic identification and assessment of suicide risk levels for both clients served and inpatient clients; suicide management plans for outpatient clients; workforce training around suicide prevention care; collaborative safety planning; effective suicidality treatment; and continuing contact and support. The Zero Suicide Organizational Self-Study can be found at http://zerosuicide.sprc.org/toolkit/lead/taking-organizational-self-study.
- **Bi-monthly data submissions**: A major component of the Breakthrough Series involved the collection of data on selected dimensions of Zero Suicide performance. The data elements were designed by SPRC and reported to the National Council on a bi-monthly basis. To assist Breakthrough Series participants navigate their data collection independently, the National Council hosted a webinar to outline the specific tactics and strategies necessary for sound and effective data collection. This webinar included comprehensive information on data collection; best practices around initial screenings; client assessments; client contacts; safety planning; deaths by suicide missed appointments; acute care transition. A resource on data collection (Data Elements Worksheet) can be found at

http://zerosuicide.sprc.org/toolkit/improve/measuring-patient-care-outcomes. In addition, bi-monthly data webinars were conducted. These webinars were used to present current data and for a group discussion of ways each group was addressing the barriers they encountered.

- **Coaching calls**: All Breakthrough Series teams participated in bi-monthly coaching calls with National Council and SPRC faculty. On average, at least three to four individuals from both the state and provider teams were present on these calls. Coaching calls served as an effective platform for the participants to talk through challenges they faced in the implementation of the Zero Suicide approach and development of strategies to move forward. They also served as an opportunity to inform best practices and identify additional opportunities for targeted technical assistance.
- **Monthly webinars**: A critical component of the Breakthrough Series included the monthly webinar series. The series curriculum was developed at the onset of the Breakthrough Series and was modified with time to facilitate learning that was responsive to the participants stated needs and other feedback gleaned from coaching calls, self-studies, and data reporting. One month was content specifically related to implementing the Zero Suicide approach and the alternate month was for the data webinar.
- **List-serve**: Many of the organizations involved in the Breakthrough Series had existing protocols including screening and assessment approaches in place at the beginning of the program. A list-serve specific to the Breakthrough Series was created to help streamline and track program communications. A Breakthrough Series list-serve also aided as an effective vehicle for participants and program faculty to share best practices and other important Zero Suicide approach protocols in real time.
- **Faculty**: The Breakthrough Series faculty was made up of national experts from the National Council and SPRC. The curriculum and program development was overseen by the National Council's Senior Integration Consultant, Joan Kenerson King, and SPRC's Director of Prevention and Practice, Dr. Julie Goldstein Grumet. The National Council's Aaron Surma served as the data analyst and provided aggregate feedback to Breakthrough Series participants on a reoccurring basis through the monthly webinars. Faculty participated in all webinars, coaching calls, and the in-person meeting.
- **Mid-year meeting**: Midway through the Breakthrough Series, the National Council and SPRC hosted a meeting in Washington, D.C. with representatives from each of the teams involved in the Breakthrough Series. The meeting served as an opportunity to bring states and providers from throughout the country to address best practices and exchange information about organizational processes for implementation. The meeting's agenda can be found in Appendix B.
- **Work plans**: Another critical element of the Breakthrough Series involved the completion and review with project faculty of a Zero Suicide Organizational and State-Level Work Plan. This process forced participating organizations to examine their practices and protocols specifically related the Zero Suicide approach. The Organizational Work Plan template can be found in Appendix C.
- **Bi-monthly reports**: In order to track and examine progress made by Breakthrough Series participants, the National Council and SPRC developed a robust bi-monthly report. These reports included specific elements that allowed the management team to track progress and

developments made by both providers and states, including the identification of barriers and proposed solutions around regulatory and budgetary challenges. The report also allowed the management team to track implementation of the specific elements of the Zero Suicide approach, including screening, assessment, counseling on access to lethal means, safety planning and care management expectations. A sample of the bi-monthly reports can be found in Appendix D.

- **Workforce Survey** – Each organization filled out a workforce survey at the start of the breakthrough series. The survey is used to assess the knowledge and self-reported competence and confidence of staff members. Survey results were not reported, but were used by each organization. A copy of the survey can be found at http://zerosuicide.sprc.org/toolkit/train/administering-workforce-survey.

Breakthrough Series Participants and Selection Process

Six teams made of a state-level government agency and provider were selected to participate in the Breakthrough Series. A Request for Applications was sent by the SPRC to state agency representatives in states that had participated in a Zero Suicide Academy or were otherwise known to have begun implementing the Zero Suicide approach.

The state-level governmental agency was defined as a government agency with the authority and ability to influence resources and/or regulations related to suicide prevention and/or behavioral health services, data sharing, and direct care provision. As the lead applicant, the state-level governmental agency was asked to be responsible for application submission, day-to-day communication with representatives from the National Council and SPRC, and assuring the team participate fully in all Breakthrough Series activities.

A provider was defined as a community-based, direct clinical care provider who either was already implementing the Zero Suicide approach to care, or was open to partnering with the state to begin this process. The provider could be a behavioral health organization, health center delivering behavioral health services, or integrated primary care-behavioral health system. Additional providers were welcome to participate in monthly group webinars and bi-monthly coaching calls, but not required to submit data.

The application was designed to elicit information about the:

- Leadership's knowledge of and commitment to the Zero Suicide approach (at both state agency and provider agency levels).
- Involvement of the right people (by position and personal engagement) and demonstrated experience with commitment to collaboration among team members and between state and provider agencies.
- Involvement of and support to suicide loss and attempt survivors in the project.
- Assurance of data collection/submission including at least suicide loss and measurement of implementation efforts.

All team dyads were made of one government agency representing the mental health authority and one behavioral health organization, with the exception of one state which included two behavioral health organizations in their team. In addition, the provider organization in one state was a state-operated outpatient provider.

Ultimately, the following six states applied and were accepted into the Breakthrough Series: Indiana, Kentucky, Missouri, New York, Texas, and Utah.

Use of Data to Drive Outcomes

Participating organizations were asked to submit four bi-monthly reports (see Appendix D for the report template). The purposes of the bi-monthly reports were to:

- Supply a brief update of Zero Suicide activities.
- Provide quantitative information about the provider's implementation of Zero Suicide.
- Describe provider and state barriers to implementation and proposed solutions to these barriers (discussed in Section 2: Lessons Learned from the Breakthrough Series).
- Track provider implementation of Zero Suicide protocols such as using standard screening and comprehensive assessment tools, completion of the Work Force Survey, and developing protocols and training around screening, assessment, counseling on access to lethal means, safety planning and care management expectations.

Breakthrough Series staff used the information on the reports to identify technical assistance needs that were addressed during coaching calls and webinars. The quantitative information was summarized and discussed during the bi-monthly data webinars. These webinars focused on successes and difficulties in tracking the metrics and ideas for using the metrics to inform each organization's Plan-Do-Study-Act (PDSA) processes. Interim consultation was also provided as needed to support data collection and PDSA efforts.

Collecting and reporting data served an important function to drive change forward, but it also served as a way for providers and the state to be accountable to each other and to keep focused on this project amidst many competing demands. On Breakthrough Series webinars, comparative data was shared amongst participants, prompting them to address outliers, discuss how to address challenge areas, and share successfully employed strategies. While information presented in this report does not tie data reports back to specific states, information presented during webinars was tied to specific states.

Quantitative Data Elements

The National Council and SPRC selected and designed seven quantitative metrics for the Breakthrough Series according to the following guiding principles:

- **Data is accessible**: it is relatively easy to collect and report and does not require protracted system changes.
- **Data is meaningful**: the results of the data, either in individual or aggregate form, are meaningful to the clinician and/or the consumer (preferably both).

- **Data elements are defined based on best known method or practice**: research provides rationale for the elements selected.
- **Data facilitates rapid change:** the data elements are collected and reported at a volume and at intervals that allow for rapid correction of interventions or processes and allow for real-time practice improvement.

The coaching team used the metrics to provide targeted technical assistance. States and providers used the metrics to inform their PDSA cycles.

When developing metrics, the goal was to have each organization report the exact same information. In practice, this was not always possible due to differences in each provider's service array, scope of implementation and ability to accurately track indicators. We encouraged each provider to follow the definition of each metric as closely as possible, but allowed for modifications due to each provider's unique situation. One such example is the two entries for state F. This is because two providers in this state were implementing the Zero Suicide approach. All parties agreed that it would be more beneficial to track the metrics separately for each provider.

Zero Suicide Breakthrough Series Metrics

Required
Metric 1: Screening Rate
Metric 2: Assessment Rate
Metric 3: Weekly Contact Rate
Metric 4: Safety Plan Development Rate
Metric 5: Suicide Deaths

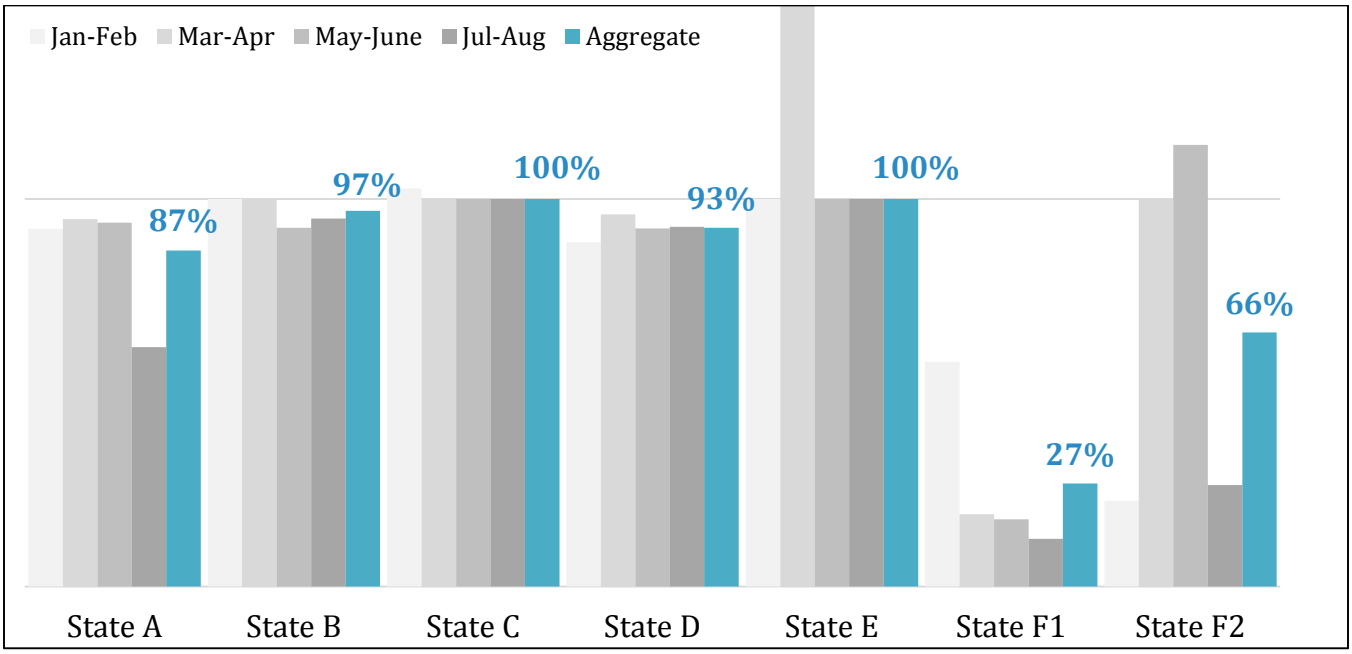
Optional
Metric 6: Missed Appointment Follow-Up Rate
Metric 7: Acute Care Transition Rate

Metric 1: Screening Rate

The purpose of Metric 1, Screening Rate, is to track the organization's progress towards screening all clients for suicide risk. The goal is a 100 percent screening rate.

- Numerator: Number of initial suicide screenings for people enrolled in the reporting period
- Denominator: Number of clients enrolled during the reporting period

Figure 1: Screening Rate over Time, By State



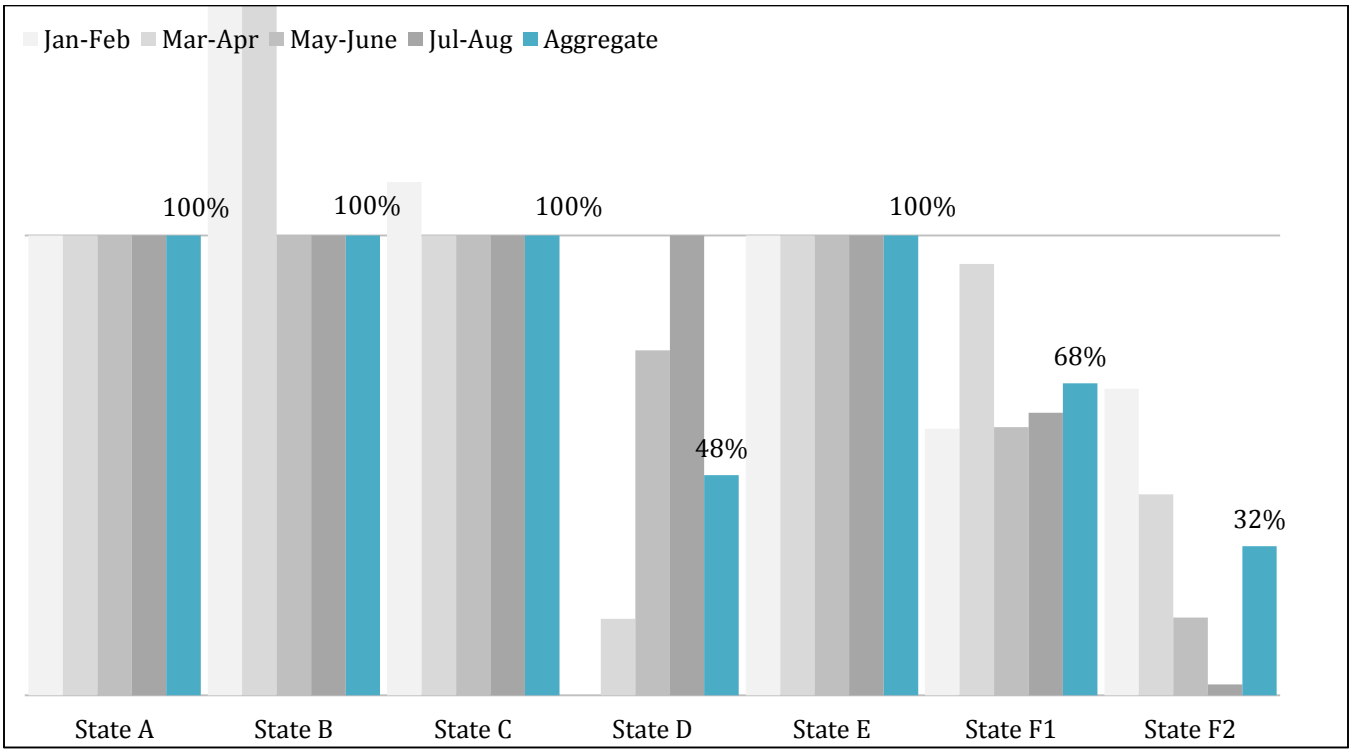
This figure shows screening rates over time for each organization. Initially, organizations had difficulty identifying the denominator for this metric (i.e. who was in their target population). This is particularly apparent in the data points that are above 100 percent. The guidance provided was to determine everyone who the provider thinks should receive a screen with the eventual goal of screening 100 percent of the people who enroll in services at the organization. Another area of challenge for some providers was to identify what screening tool and what protocol to use. Providers that struggled to track their screening rates were advised during coaching calls to incorporate screening into existing tools or processes. The coaching helped several providers realized they asked sound screening questions during their standard intake, but did not identify these questions as such and did not have a standard process for moving to assessment when the screen was positive. As these two challenges were addressed five of seven organizations were able to implement screening protocols that resulted in near-100 percent screening rates by the end of the series.

<u>Metric 2: Assessment Rate</u>

The purpose of Metric 2, Assessment Rate, is to determine if every client who screened positive for suicide risk then received a comprehensive risk assessment. The goal is a 100 percent assessment rate.

- Numerator: Number of clients who screened positive for suicide risk and had a comprehensive risk assessment during the reporting period.
- Denominator: Number of individuals who screened positive for suicide risk during the reporting period.

Figure 2: Assessment Rate over Time, By State



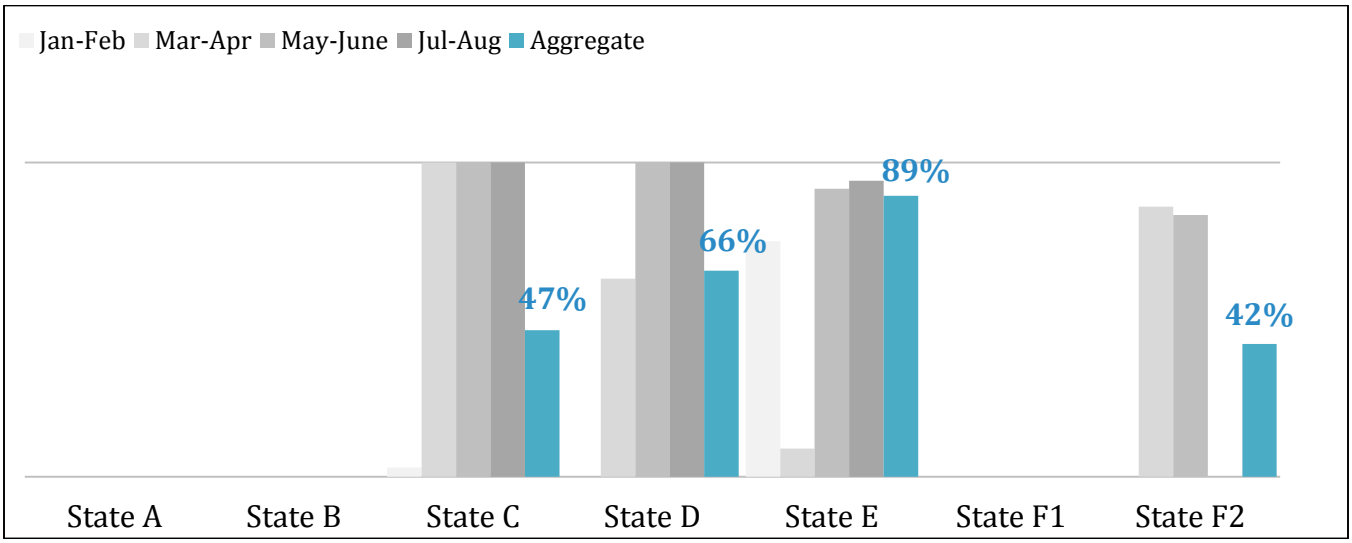
This figure highlights the difficulty that some organizations had in collecting these data. One team was unable to collect the metric in the first two reporting periods, while another team was unable to collect the metric in the first reporting period. A different team had difficulty defining the denominator in the first reporting period. After the first reporting period, organizations realized that a positive screen was not always followed by an assessment. Building an assessment into the Electronic Health Record, preferably with a hard stop, is a powerful strategy when available. Organizations also addressed this need by training to staff about how to perform assessments and stressing the importance of assessments. By the end of the series, most providers were able to perform comprehensive assessments with 100 percent of intended clients.

Metric 3: Weekly Contact Rate

The purpose of Metric 3, Weekly Contact Rate, is to ensure that all clients enrolled in a Suicide Care Management Plan are contacted at least once every seven days. The goal is a 100 percent weekly contact rate.

- Numerator: Number of individuals who have had contact every seven days (or less) during the reporting period.
- Denominator: Number of individuals enrolled in a Suicide Care Management Plan during the reporting period.

Figure 3: Weekly Contact Rate Over Time, By State



Metric 3, Weekly Contact Rate, was difficult for several organizations to measure. Unlike Metrics 1 and 2 (Screening and Assessment rates), the data necessary to calculate this measure is not usually available from an Electronic Health Record report. For example, some organizations had difficulty identifying individuals with Suicide Care Management Plans.[1] Others had difficulty capturing the timing of contacts with clients (e.g., whether less than seven days had elapsed between each contact). One team was able to track the metric on an offline Excel-based document.

The challenges associated with tracking this metric demonstrate the limitations many Electronic Health Record systems have with respect to close monitoring of utilization of services, absent a billable encounter that is tracked in the system; most encounters for purposes of this metric were telephone-based. Future implementers of the Zero Suicide approach are encouraged to develop an offline method of tracking this metric if the capability is not present in their Electronic Health Record.

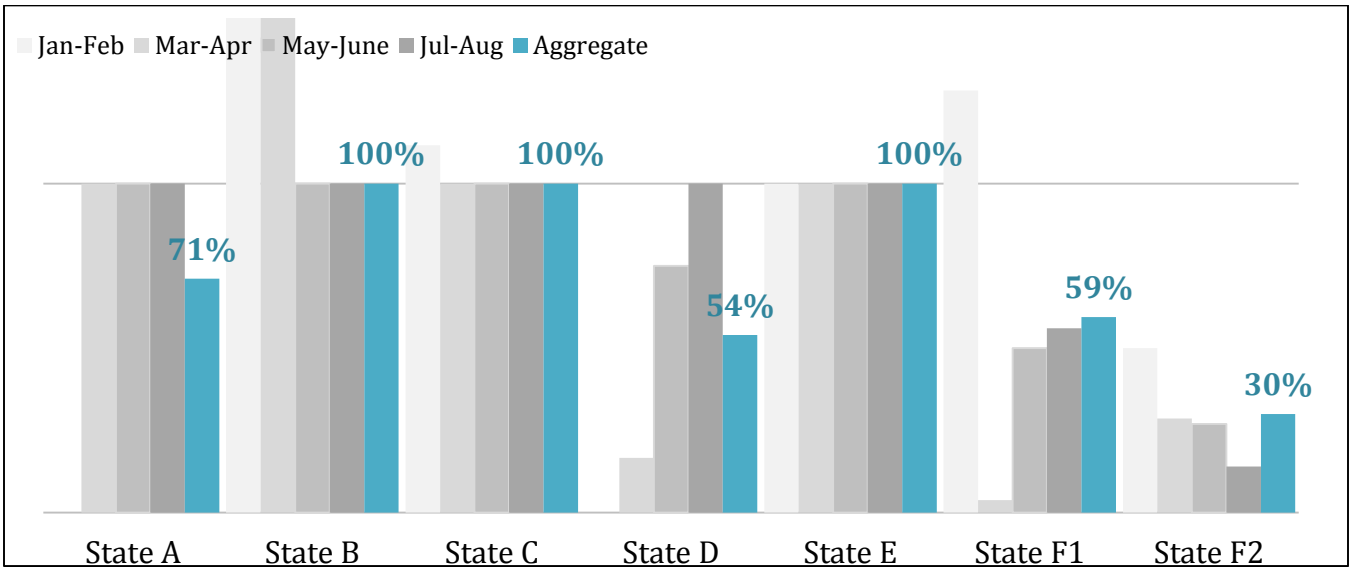
<u>Metric 4: Safety Plan Development Rate</u>

The purpose of Metric 4, Safety Plan Development Rate, is to ensure that safety plans are developed on the same day the client is screened. The goal is a 100 percent safety plan development rate.

- Numerator: Number of individuals with a safety plan developed on the same day as screening during the reporting period.
- Denominator: Number of individuals who screened positive for suicide risk during the reporting period.

[1] The Suicide Care Management Plan outlines the steps an organization takes to provide care for those who have a positive suicide risk screen. The plan should provide for same-day access to behavioral health care, safety planning, counseling on reducing access to lethal means and protocols for follow-up with various professionals on the suicide care team.

Figure 4: Safety Plan Development Rate over Time, By State



While not all providers had the requisite information in their Electronic Health Record, the required fields were easy to add, as the presence of a safety plan can be a simple yes/no checkbox. Once this function was added, most providers were able to confirm that safety plans were developed on the appropriate day. For providers without an Electronic Health Record, however, this requires a manual tracking field which presents a challenge. This is another reminder of the uneven readiness of behavioral health providers to participate in care management activities.

Metric 5: Suicide Deaths

The purpose of Metric 5, Suicide Deaths, is to determine if the organization has achieved the ultimate goal of zero suicides in the population of people known to the organization.

- Numerator: Number of clients who died by suicide during the reporting period.
- Denominator: Number of clients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen.

Figure 5: Suicide Deaths

	Known deaths from suicide during the series:	Total number of individuals who received behavioral health services during the series:
State A	3	14,646
State B	6	1,454
State C	4	1,648
State D	0	889
State E1	0	534

State E2	5	13,459
State F1	0	1,590
State F2	0	994

Tracking suicide deaths was the most difficult metric for Breakthrough Series participants. The biggest issue was the lack of reliable information about the cause of death for clients. Providers reported difficulty at the medical examiner level (unwillingness to put suicide on death certificates and the frequent time lapse between the death and final confirmation of cause of death) and states struggled to identify a reliable source for suicide data. Some organizations relied on word-of-mouth to identify individuals who died by suicide reviewing local newspapers or reports from family members or other support people. The count of known deaths by suicide is therefore unreliable for all participants. Significantly, deaths by suicide for people under care has not been adopted as a measure for health care/behavioral health organizations. In the absence of an endorsed measure, it will be much harder to improve suicide care and to assess its impact.

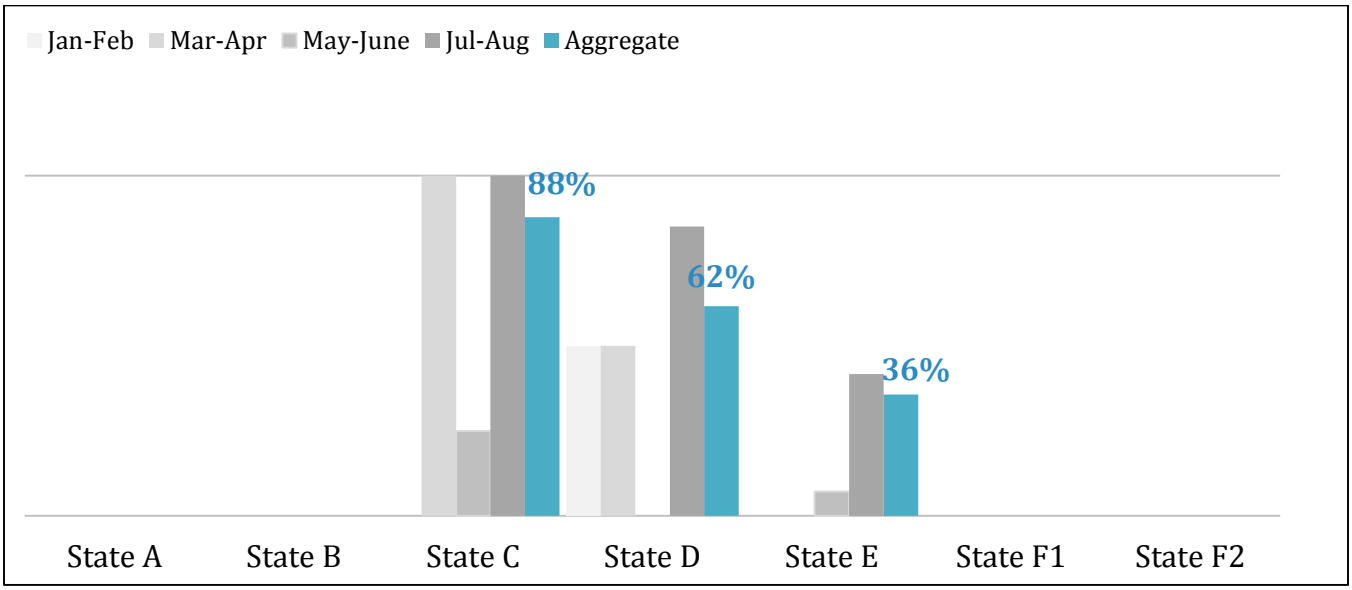
Providers also struggled with definitions of their population under care. The wording of the numerator was changed after the first reporting period at the request of providers. Given that the intent of the metric is to note the number of deaths in the entire population of people who are engaged with the provider, the numerator is defined as number of open case files. Providers found this definition difficult and the information pulled unreliable. Future Zero Suicide approach implementers are advised to spend time creating a definition of the numerator and denominator that is achievable with the understanding that it will take time to make the metric reliable. Potential definitions include people who have received service within a certain time frame (i.e., last 90 days, last six months). In addition, state and national leadership to define this measure and hold organizations accountable would be invaluable. Of paramount importance is the recognition by organizations that they should measure deaths by suicide beyond the current seven days stipulated by the Joint Commission on Accrediting Healthcare Organizations (JCAHO).

<u>Metric 6: Missed Appointment Follow-up Rate</u>

The purpose of Metric 6, Missed Appointment Follow-Up Rate, is to ensure that all clients who missed an appointment were quickly contacted to keep them safe and engaged with treatment. Due to the anticipated difficulty in tracking it, this metric was deemed optional at the start of the series. The goal is a 100 percent missed appointment follow-up rate. While this metric is difficult to track, it is a critical measure and it is recommended that future Zero Suicide implementers develop tracking systems. One possible strategy is to build an alert for missed appointments through a clinical pathway in the Electronic Health Record for people who are at risk.

- Numerator: Number of individuals with missed appointments who received contact within 12 hours of the appointment during the reporting period.
- Denominator: Number of individuals with a Suicide Care Management Plan who missed an appointment during the reporting period.

Figure 6: Missed Appointment Follow-up Rate over Time, By State



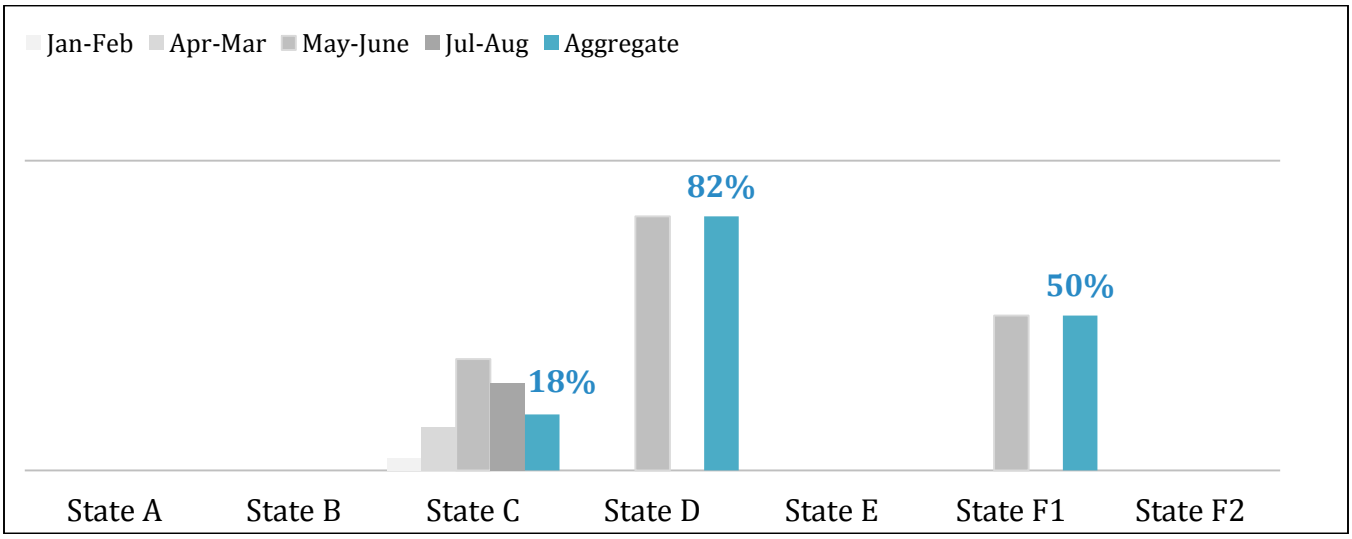
Three of the seven providers attempted to track this optional metric, and all three mentioned that the numbers were unreliable. To improve the reliability of this metric, one state waited for their new Electronic Health Record to track this metric. Organizations that attempted to track this information outside of their Electronic Health Record found it difficult to convince staff to keep the detailed call records needed to track this metric. For these organizations, it is recommended that staff are shown the importance of tracking this critical information. One method to achieve this is through mandated monthly data conversations with all staff. Given the difficulty experienced in tracking this metric, it is challenging to draw conclusions from the data with confidence. The difficulty involved in measuring this variable reveals that performance on this important aspect of suicide care is likely uneven and inadequate in most care settings.

<u>Metric 7: Acute Care Transition Rate</u>

The purpose of Metric 7, Acute Care Transition Rate, is to ensure that individuals with a Suicide Care Management Plan who had a hospital or Emergency Department (ED) admission (regardless of cause) were contacted within 24 hours of transition from acute care. Due to the anticipated difficulty in tracking it, this metric was deemed optional at the start of the series. The goal is a 100 percent acute care transition rate. As with the other optional metrics, it is strongly recommended that future implementers consider ways to develop strategies to tighten their connections with local emergency rooms and hospital discharge planning staff to ensure that people who are at risk receive timely follow up to address the increased risk for suicide that is known to follow hospital discharge.

- Numerator: Number of individuals contacted within 24 hours of transition during the reporting period.
- Denominator: Number of individuals with a Suicide Care Management Plan who had a hospitalization or ED admission during the reporting period.

Figure 7: Acute Care Transition Rate over Time, By State



Acute care transition rate is as difficult to track as missed appointment follow-up rate, and for the same reason, staff inconsistently track the timing of contact accurately to provide a reliable metric. The ideal solution is to build this information into the Electronic Health Record. If this is not possible, one must convince staff of the importance of accurately tracking attempted and actual contact with patients during transition from acute care. Given the difficulty in tracking this metric, it is difficult to draw sound conclusions from the data. The difficulty involved in measuring this variable reveals that performance on this important aspect of suicide care is likely uneven and inadequate in most care settings.

Qualitative Data Elements

Every two months, teams submitted a report outlining barriers and solutions across various categories, as outlined below. [See Appendix D for the bi-monthly report template.]

Provider barriers and proposed state/provider solutions:

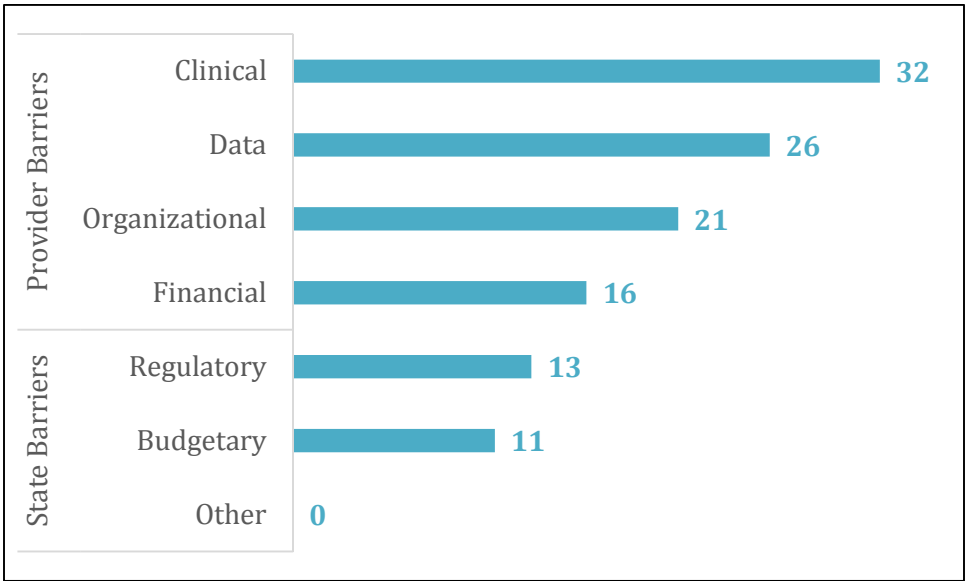
- Clinical
- Data
- Organizational
- Financial

State barriers and proposed state solutions:

- Regulatory
- Budget
- Other

Respondents indicate the specific issues that are making implementation of the Zero Suicide approach difficult in these areas and reported their plan for addressing those barriers. This is the frequency of each type of barrier reported:

Figure 8: Number of Barriers in Bi-Monthly Reports - By Category



The following is a theme analysis of barriers in each category along with an example from each theme that represents the type of barrier that was categorized thusly:

<u>Clinical</u>

22 responses mentioned need to train staff on a specific component of Zero Suicide.

- Barrier: "We have had difficulty with fidelity to safety planning."
- Solution: "We hosted a training on safety planning."

10 responses mentioned the need to increase the type/amount of clinical services.

- Barrier: "We need to develop an intensive treatment track."
- Solution: "We hired a new staff that offers dialectical behavior therapy group therapy around suicide prevention and two support groups for people who have attempted suicide."

<u>Data</u>

18 responses mentioned the difficulty in building the data elements into the provider's Electronic Health Record.

- Barrier: "Electronic Health Record does not have the capacity to track all required metrics."
- Solution: "Tracking metrics in excel while building the capacity in the Electronic Health Record."

Eight responses mentioned the data metrics being unavailable.

- Barrier: "Our list of high-risk people wasn't being updated fast enough."

- Solution: "IT staff put the list on the shared drive and clinicians update it whenever there's a change."

Organizational

13 responses mentioned the difficulty in developing a standard suicide pathway to treatment.

- Barrier: "We are still struggling with having a standard suicide pathway of treatment protocol."
- Solution: "Provider still working with leadership to get a standardized protocol in policy/procedures."

Six responses mentioned the lack of qualified staff at the provider.

- Barrier: "We have difficulty admitting clients to the clinic quickly due to the shortage of prescribers."
- Solution: "We are applying for telepsychiatry through the Office of Mental Health."

Two responses mentioned the difficulty of balancing the needs of the implementation team with other tasks for staff.

- Barrier: "Keeping goals and timelines of implementation team while balancing increased volume of work."
- Solution: "Problem solving and technical assistance."

Financial (provider)

Seven responses mentioned the financial burden of training clinicians.

- Barrier: "Travel costs for trainings."
- Solution: "We applied for grant funds to cover cost of training."

Six responses mentioned the increase in costs associated with data collection.

- Barrier: "Most tracking of data will have to be done by hand. This will require additional personnel time."
- Solution: "Streamline how we collect information about deaths by suicide"

Three response mentioned the lack of funding for these services.

- Barrier: "There is no funding to support these ongoing efforts."
- Solution: "The state was willing to cover the cost of AMSR training."

Regulatory

Eight responses mentioned the difficulty in standardizing practices statewide.

- Barrier: "Suicide Prevention is not required for school personnel and other disciplines."
- Solution: "[State Senate bill] filed adding Suicide Prevention as an option for continuing education/career ladder for teachers and will require each school system to develop a suicide prevention plan."

Five responses mentioned the inconsistency of death data.

- Barrier: "We have difficulty tracking death data with any consistency."

- Solution: "We recommended changes through our state policy workgroup."

Budgetary

11 responses mentioned a lack of state funding.

- Barrier: "$30 million cut from public behavioral health budget in 2014 and 2015."
- Solution: "We will leverage suicide prevention and other grant funds for the pilot project."

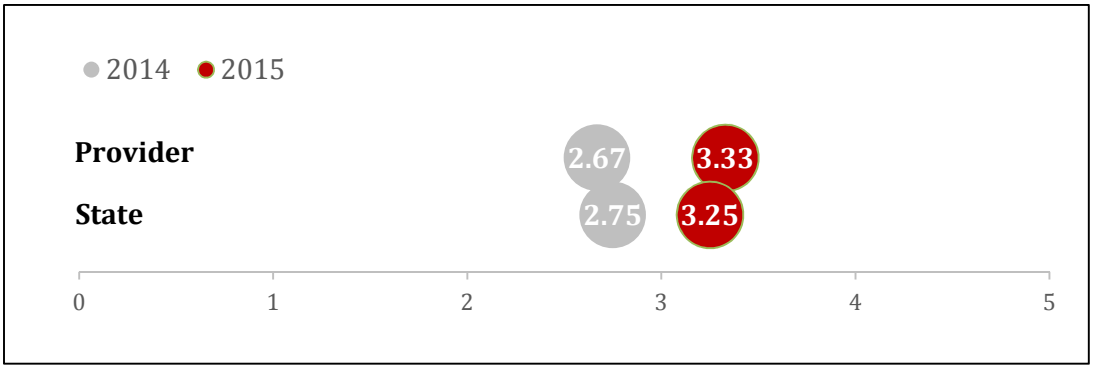
Organizational Self-Study

As described in the Breakthrough Series Activities section, nearly all state and provider teams were asked to complete an Organizational Self-Study tool at the start and end of the Breakthrough Series. The 2014 results were used to inform the technical assistance provided and to help guide each team's individual work plan. The assessment tool asks the respondent to rate themselves from 1-5 over 14 items that cover the dimensions of suicide care.

The following graphs show the average score for all states and all providers at the pre-test in 2014 and the post-test in 2015. For metrics where there was change from the pre-test to the post-test, the post-test result is the only result that appears in the chart.

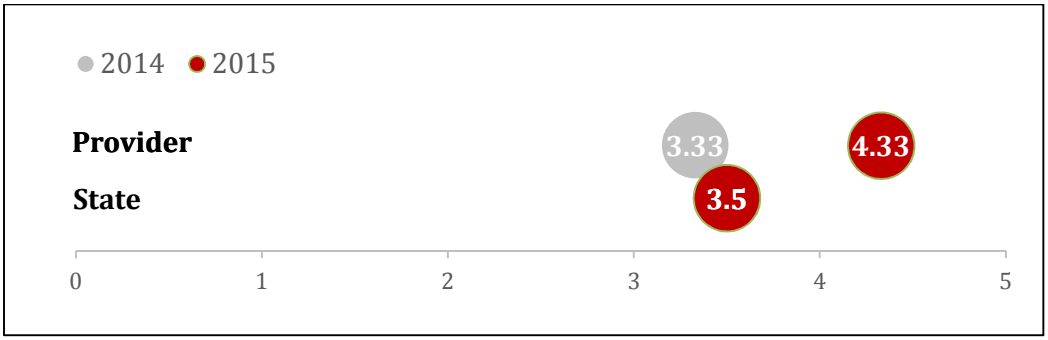
Developing a leadership-driven, safety-oriented culture:

Figure 9 - What type of formal commitment has leadership made to reduce suicide and provide suicide safer care among people who use the organization's services?



Two providers and one state improved.

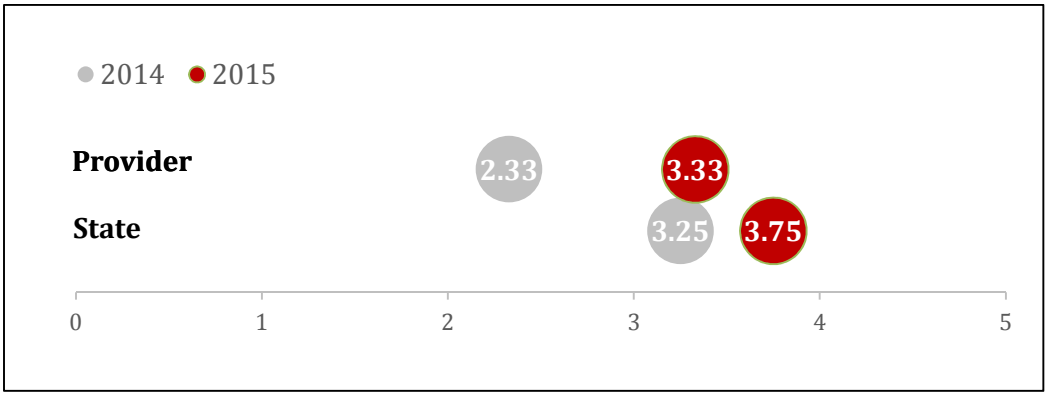
Figure 10 - What type of formal commitment has leadership made to reduce suicide and provide suicide safer care among people who use the organization's services?



Two providers and one state improved.

<u>Suicide attempt and loss survivors in leadership and planning roles:</u>

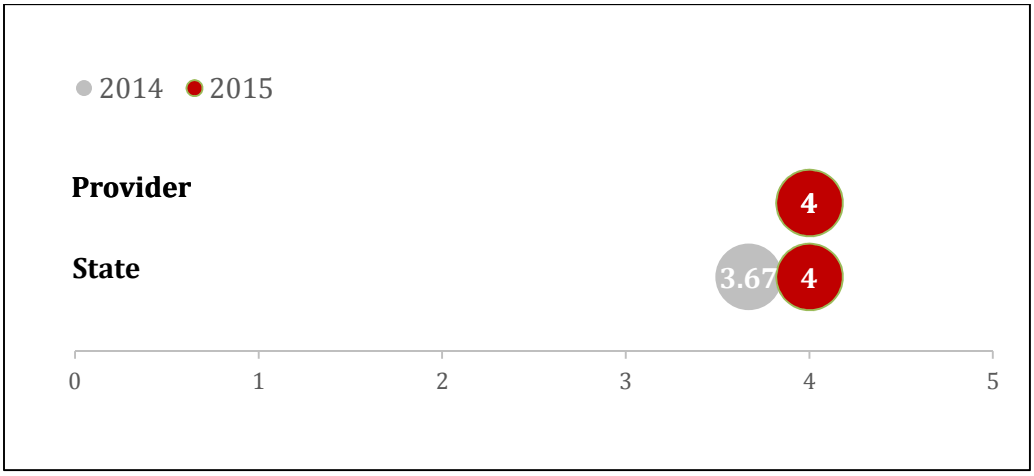
Figure 11 - What is the role of suicide attempt and loss survivors in the development of the organization's suicide care policy?



Two providers and two states improved.

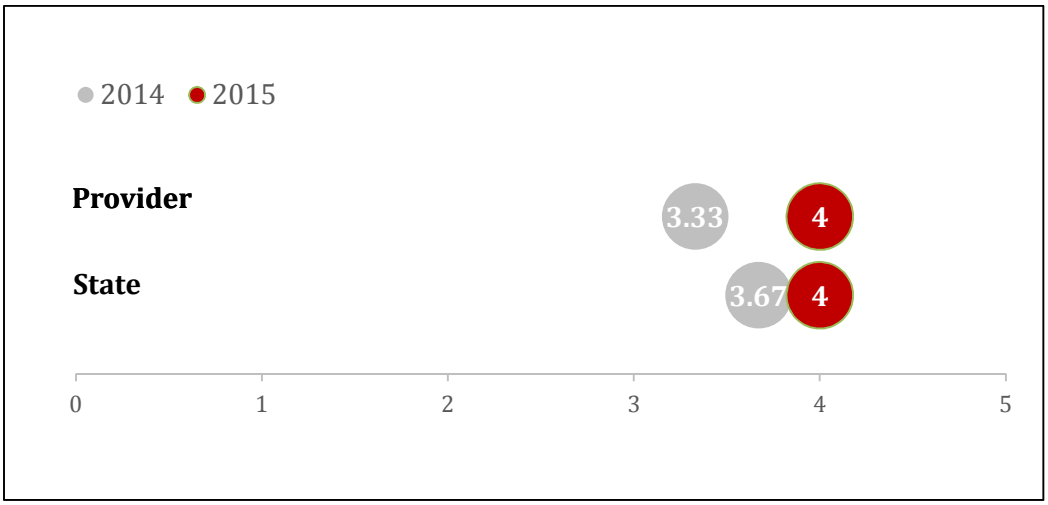
Systematically identifying and assessing suicide risk levels:

Figure 12 - How does the organization screen suicide risk in the people we serve?



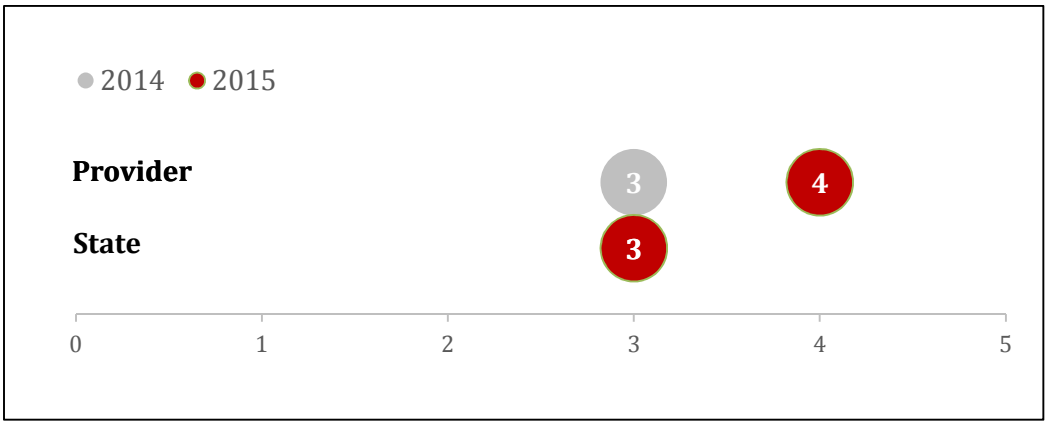
One provider and two states improved.

Figure 13 - How does the organization assess suicide risk in the people served?



Two providers and two states improved.

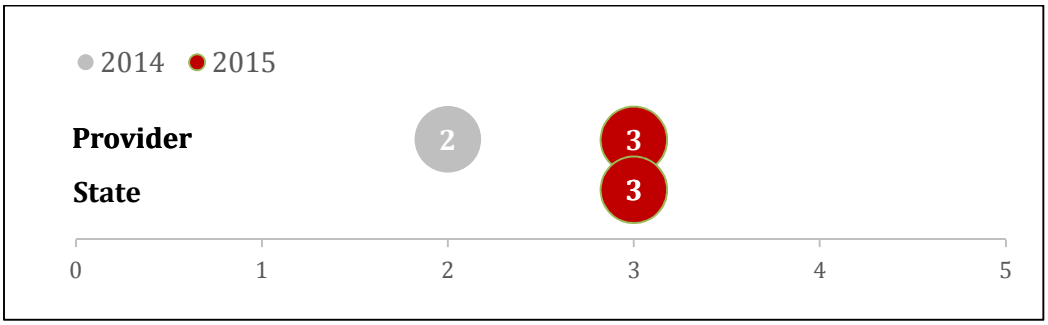
Figure 14 - When does the organization assess and reassess suicide risk in the people served who screen positive?



One provider and zero states improved.

<u>Organization has a clear suicide management plan for outpatients:</u>

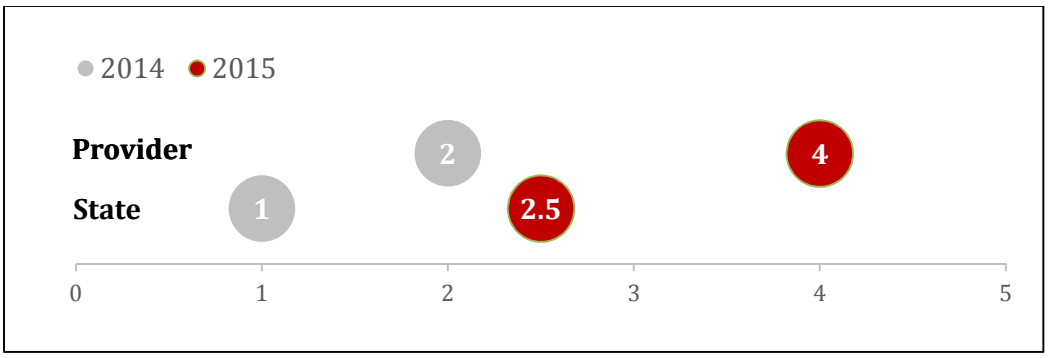
Figure 15 - Which best describes the organization's approach to caring for and tracking people at risk for suicide?



Two providers and zero states improved.

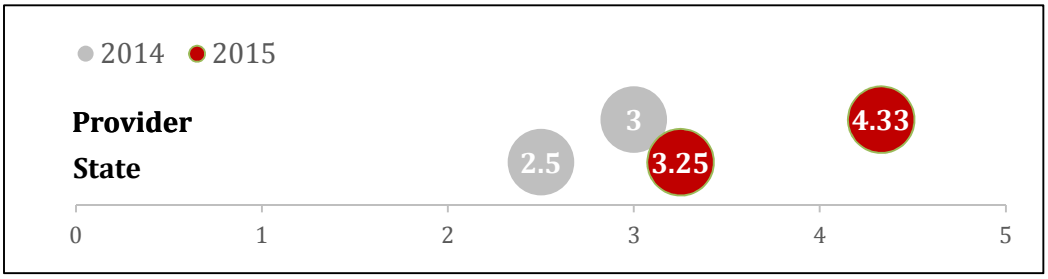
Competent, confident, and caring workforce:

Figure 16 – How does the organization formally assess staff on their perception of their confidence, skills and perceived support to care for individuals at risk for suicide?



Three providers and two states improved.

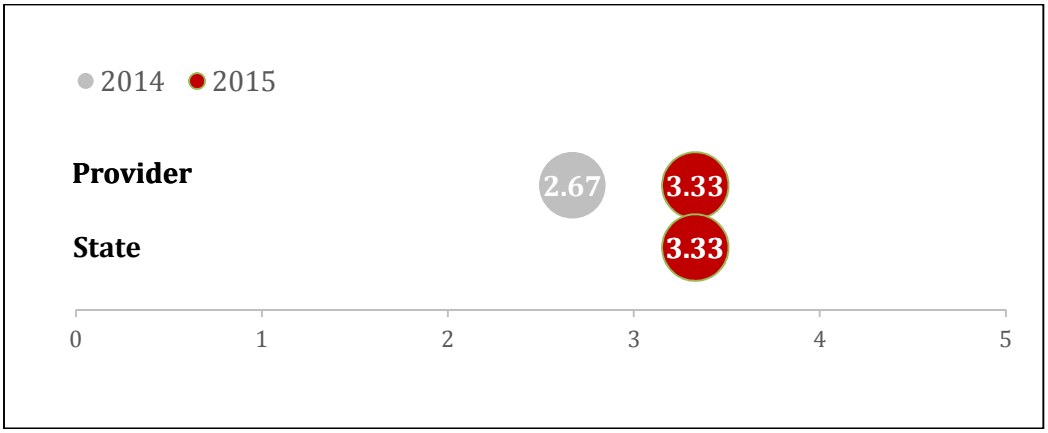
Figure 17 – What basic training on identifying people at risk for suicide or providing suicide care has been provided to staff?



Two providers and two states improved.

Collaborative safety planning (for use with outpatients and/or at time of discharge for inpatients):

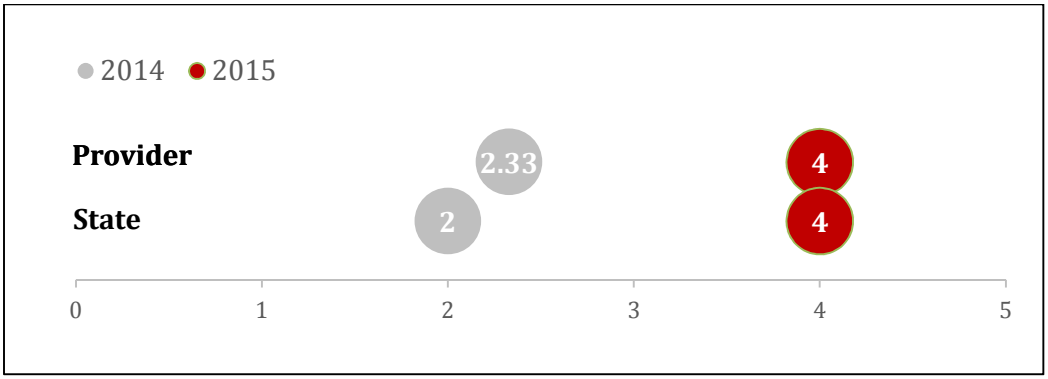
Figure 18 – What is the organizations approach for collaborative safety planning when an individual is at risk for suicide?



Two providers and one state improved.

Collaborative safety planning and restriction of lethal means for outpatient settings:

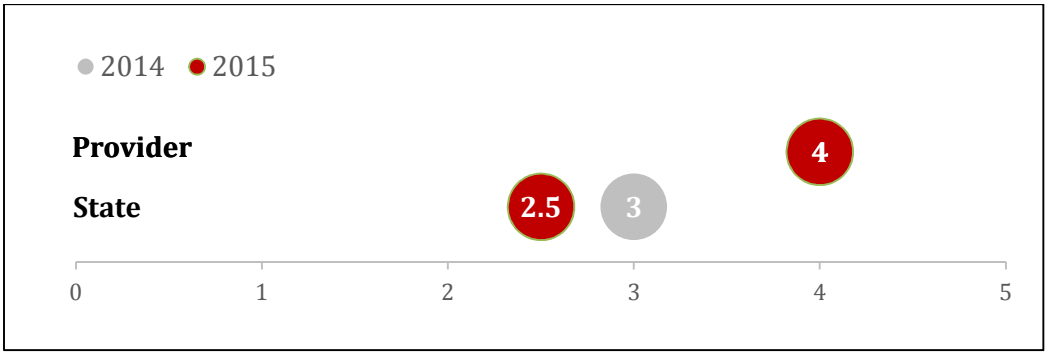
Figure 19 – What is the organization's approach to lethal means reduction identified in an individual's safety plan?



Two providers and two states improved.

Collaborative safety planning and restriction of lethal means for inpatient settings:

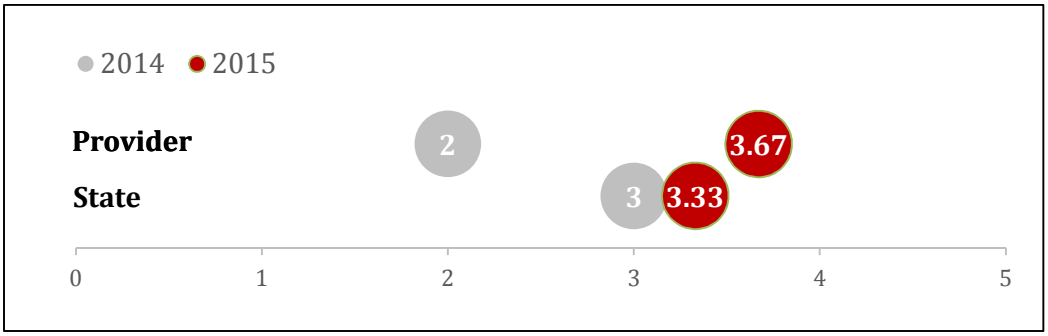
Figure 20 – What is the organization's approach to lethal means restriction?



One provider and one state improved.

Effective treatment of suicidality:

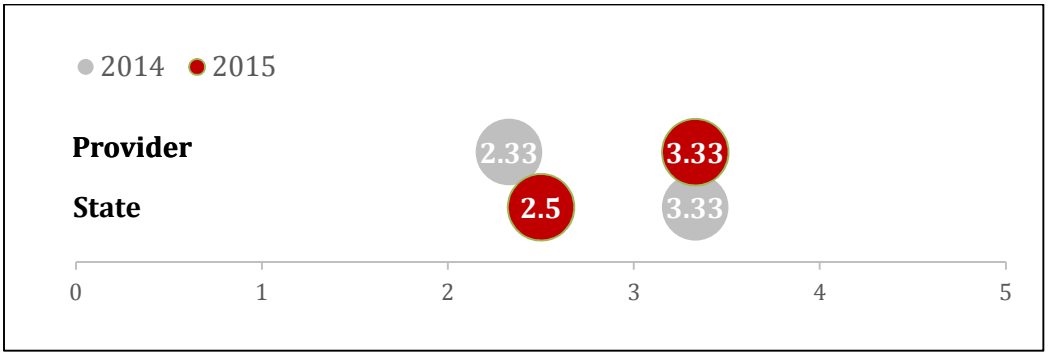
Figure 21 – What best describes the treatment/interventions specific to suicide care used for patients at risk?



Three providers and one state improved.

Continuing contact and support:

Figure 22 – What is the organization's approach to engaging hard to reach individuals or those who are transitioning in care?



Two providers and one state improved.

Providers experienced the largest increase in:

- How does the organization formally assess staff on their perception of their confidence, skills and perceived support to care for individuals at risk for suicide?
- What is the organization's approach to lethal means reduction identified in an individual's safety plan for outpatient settings?
- What best describes the treatment/interventions specific to suicide care used for patients at risk?

Providers experienced the smallest increase in:

- What is the organization's approach to lethal means reduction identified in an individual's safety plan?
- How does the organization screen suicide risk in the people we serve?

States experienced the largest increase in:

- What is the organization's approach to lethal means reduction identified in an individual's safety plan for outpatient settings?
- How does the organization formally assess staff on their perception of their confidence, skills and perceived support to care for individuals at risk for suicide?
- What basic training on identifying people at risk for suicide or providing suicide care has been provided to staff?

States experienced the smallest increase in:

- What is the organization's approach to engaging hard to reach individuals or those who are transitioning in care?
- What is the organization's approach to lethal means reduction identified in an individual's safety plan?

Recommendations for Instituting a Data-Driven Approach to Care:

- When Electronic Health Records cannot support tracking of a particular metric, consider developing alternative strategies for data collection and monitoring for quality improvement. For instance, weekly contact rates for people who have been identified as at risk for suicide can be tracked using Excel; the relatively low number of clients needing this level of follow up will hopefully not place too high a burden on staff time.
- Spend time developing definitions for metrics, and consider (1) what data inputs drive the numerators and denominators so that it measures what it is intended to measure, and consider (2) what level of specificity supports quality improvement at a level that is meaningful for the organization. For example, screening and assessment rates could be collected at a population level (adults, children) or a clinic level (Site A, Site B).
- Recognize that it will take time for metrics to become reliable. Suicide death rate is unreliable for many states. These organizations are working on improving the reliability of suicide death data while simultaneously improving the number of suicide deaths.
- When first implementing metrics for suicide safer care, consider following the same principles used for the Breakthrough Series and select those that are accessible, meaningful, rooted in best practices, and facilitate rapid change. (See *Quantitative Data Elements* earlier in Section 1 for additional guidance.)
- Review metrics with all staff members who drive that metric. When reviewing metrics for contact after transition from acute care, it is helpful to have someone involved in discharge at the acute care provider and the clinician who is responsible for making contact with the individual after transitioning out of acute care.

> *"Pursuing greater reliability of metrics is a parallel process to improving upon the metric itself. For example, just as you are working to refine and improve your screening process, you are also working to make sure the metric itself comes from reliable data."*

SECTION 2: LESSONS LEARNED FROM THE BREAKTHROUGH SERIES

Several themes emerged from the quantitative and qualitative data collected throughout the Breakthrough Series.

State Leadership is Critical

While providers quickly gained a sense of their own organizational vision regarding implementing the Zero Suicide approach, the vision and direction set forth by the state was a key starting point for them. This leadership can take many forms. A state-level Zero Suicide Academy, a two-day in-person intensive workshop to launch organizations with a high level of readiness, is one way of starting the conversation and beginning to move toward implementation. Building Zero Suicide policies and practices into contracting requirements and providing training specific to Zero Suicide practices is another.

The evidence on adoption of innovations and our experience in this Breakthrough Series confirms that there is a quality of leadership however that is as, or more important, than the strategies that are employed. Leadership that is visionary and highly persistent, that sees working in partnership with providers and communities to make these changes happen as a high priority amidst many competing priorities is the most likely to be able to drive change forward. In the absence of persistent state-level leadership, an innovation as complex as the Zero Suicide approach is unlikely to be adequately enough

adopted in the behavioral health sector to make a dramatic difference in the unacceptable levels of deaths among people who receive care.

It is expected that this finding will also generalize to the much larger health sector (primary care, emergency departments, hospitals, and mainstream health plans), where individuals on average may have lower levels of risk, but where the population under care is much larger and where a great majority of suicides among health care patients occur. On the other hand, it is not known what organizations at the state or purchaser level are able and willing to exert this kind of leadership. This is a fundamental challenge to be addressed if we are to substantially reduce deaths by suicide.

System- and Organizational-Level Data are Catalyzing

The collection and use of data to drive change was a central component of the Breakthrough Series, and proved to have a catalyzing effect on the teams and how they organized themselves for change. The specific metrics, Organizational Self-Study, and workforce survey all provided a non-judgmental, objective lens through which teams could develop work plans.

While the state vision is important, the Organizational Self-Study and workforce survey brought things quickly down to the ground by providing clear information about current strengths and weaknesses in the specific provider organization. In many cases, the team's analysis of their current care suggested that it, while well-intentioned, was not optimal for those at risk for suicide. The workforce survey came as a surprise to many providers in terms of how unsure their staff were in handling people with symptoms of suicide short of hospitalization. The data created an opportunity for increased buy-in among staff for additional training.

The systematic use of quantitative metrics – such as screening and assessment rates, or follow up contacts for missed appointments – also helped hold up a mirror for provider organizations. This data created a clear sense for leadership teams of what was happening at their sites, rather than an amorphous statistic that represented the health care field as a whole. The use of specific data metrics helped leadership teams gain a concrete focus for their efforts.

> *"This work started with Henry Ford and the [Quality Improvement] initiative; they stumbled on suicide. It's measurement-driven care. Until you install the metrics, it won't click that you need to do something different for the patient."*

One frequent focus of technical assistance during coaching calls was how to act on data once it had been reported. Initially, providers were worried about data that showed a significant need for improvement and had to be coached through the process of learning to ask what can be learned from the data. This often led to a more sophisticated understanding of barriers to care, and the creation of new strategies for quality improvement.

Ongoing Implementation Support Builds and Maintains Momentum

Implementing the Zero Suicide approach is a complex change process. While the toolkit provides valuable clarification of direction with concrete tools and suggested trainings, (many of which are available online at no cost) implementing the process is complex and requires change at many levels of the organization. It seems likely that the presence and promotion of the Zero Suicide approach model, and a website that provides access to the tools, are not sufficient to produce the levels of change that will fundamentally alter the rate of suicide deaths in the "health care neighborhood." First and foremost, health care organizations need to recognize that suicide is preventable and that evidence-based tools exist to identify and treat those at risk, much like they would for any physical health problem but that are often overlooked or are even unaware of when it comes to suicide.

> *"It's easy for the State to come in and say 'fix it.' Through using the tools available – self-assessment, workforce development, the organization is able to see for themselves where there are gaps and organize around it. The data then runs parallel to that process – look where you started, look where you are now, look at how you're improving and outstanding questions, and make practice change and stick."*

Clinicians need to change long held misunderstandings about how to approach care for people with thoughts of suicide, and new pathways based on evidence need to be implemented. Improved partnerships with emergency rooms and hospital discharge planners need to be sought and developed. Electronic Health Records need to be modified to include the chosen tools for screening and assessment, and ultimately need to integrate a full clinical pathway for suicide care.

These changes are all interconnected and they require management of the change process. Organizations that form implementation teams that meet regularly, focus on a developed work plan, and continue to manage the change through implementation and beyond are more likely to succeed.

All participants in this Breakthrough Series identified the external technical assistance in terms of data support, the regular coaching calls and the structured opportunities to learn from others across the country who were attempting the same kind of change as critical to their development and future success.

Workforce Needs Additional Training

From gate keeper training to evidence-based clinical approaches, suicide safer care relies on a well trained staff. For organizations operating on tight margins, taking people out of billable care for training can be a challenge. A combination of online and face to face training can ease some of this burden but training is critical to shifting the culture of organizations and improving the skills of all staff, especially clinical staff. While difficult to measure, having staff who feel more confident in their care and able to meet the challenges that people with suicidal thoughts present may be more likely to stay in their roles, more likely to be engaging with the people they serve and more likely to feel successful, and ultimately achieve better outcomes.

Improving the skills of clinical supervisors is critical to this effort. Particularly as trainings are being conducted and new skills, interventions and pathways are being tested and developed there is a need for more, not less supervision, even for licensed and "experienced" staff, to drive the practice change forward.

> *"Can you imagine being a consumer in a suicide crisis and the person who is guiding you through the process is more scared than you are, or undermines the care being provided? It's the elephant in the room. They don't prepare you well in graduate school."*

Need for Balance between Mandate and Guidance

As states and providers move forward with implementing a Zero Suicide approach there are multiple training programs that support this and many ways to move change forward. For states and organizational leadership, the challenge is to find a balance between a totally prescribed "plug and play" approach and leaving all options open. State and provider participants in the Breakthrough Series identified finding a balance, offering a couple choices, a limited data reporting set and some flexible timeframes as key to allowing the initiative to move forward. At the same time, there was also recognition that at some point these practices and approaches need to be built into required contract elements in order to keep this as a priority within busy systems of care.

Capability of Electronic Health Records Major Driver of Implementation Speed

Many of the participants in the Breakthrough Series did not have an Electronic Health Record. For those with Electronic Health Records, the capacity to modify the system to deal with care requirements is also variable. Both of these variables affect the ability to track the required data effectively and generate reports varied based on the Electronic Health Record system in place. Obviously, the more of these metrics that have to be calculated manually, the more challenging the tracking becomes and the more likely an organization will give up their processes to fully implement the Zero Suicide approach to care.

As more and more organizations move to Electronic Health Records, it is important that providers consider the data reporting elements that will help this initiative move forward and build these into their Electronic Health Records. In the absence of these data reporting elements, providers found ways to track these elements using Excel spreadsheets. This increases the administrative burden on providers, but allows for data-driven change and early recognition of where the gaps in approach exist. Sites reported that data was, for many of them, the driving force in establishing organizational buy-in to adopting new care policies. The data spoke for itself that 1) care was not optimal and 2) when attention was shifted explicitly to suicide care, outcomes improved. Therefore, it is imperative that sites develop mechanisms to obtain and review data, even if it is sluggish at the beginning as Electronic Health Records catch up.

Managed Care Organizations and Other Financing Policies Create Barriers to Zero Suicide

In states where Managed Care Organizations (MCO) are a major force, these entities often were unaware of the Zero Suicide approach. MCOs often have an internal risk stratification tool that they use to drive approvals for care, and this is not always aligned with the data that emerges on an evidence-based suicide assessment. For example, close contact with people on a suicide care management plan is an essential aspect of the Zero Suicide model, but approvals may be required to

increase the frequency of contacts. Payment for increased face-to-face contacts/visits for individuals who are in outpatient clinic care may be problematic. As a result, receiving approvals for appropriate follow up care can be challenging.

Even in states without MCOs driving authorization, Breakthrough Series participants had extensive conversation about which elements of the Zero Suicide approach could be paid for through existing funding streams and which would require additional funding. The clinical elements (screening, assessment, intervention, and follow-up after discharge) are all funded services within standard outpatient benefits. Coverage for data collection and analysis becomes an overhead expense, as does training and supervision of staff. And as mentioned above, reimbursement for frequent or mobile contacts may be challenging.

Culture Change Takes Time

As was noted in the introduction, the movement to becoming an organization that is data-driven, focused on measurable quality, understands suicidal ideation as a unique symptom, involves all staff in the Zero Suicide approach and is prepared with many approaches in the toolkits of clinicians is a transformative change. This is not accomplished in nine months or in one year and so this takes persistent, focused attention to the process of change, the implementation strategies occurring and the data that confirms the change. It also requires attention to the vision that is driving change and using that vision as the impetus to correct course when processes and procedures begin to pull in another direction. Without visionary and determined organizational leadership, attention to identifying early adopters and champions, concerted planning and implementation attention and a dogged persistence in driving the change forward, this culture change will not be achieved and we will continue to lose lives to suicide, including those who come to behavioral health care organizations expecting to receive help.

SECTION 3: RECOMMENDATIONS FOR STATE AND FEDERAL EXECUTIVE BODIES, AND SPRC

The dominating themes required to implement the Zero Suicide approach that emerged through the Breakthrough Series included: the need for visionary, persistent and smart leadership at both state and provider levels, catalyzing the role of data to organize ongoing change processes, and the critical value of highly focused coaching, training and ongoing technical assistance.

Recommendations for State Executive Bodies

Recommendation: Recognize that in order for significant change to occur, there needs to be focused planning and attention from states with clarity of direction and rapid movement to create buy-in from a small part of the provider community that can be built on in the future.

States organizations are encouraged to take the conceptual lead, plan a Zero Suicide Academy, structure an implementation process, and guide the process with practice change support. Leadership

at the state-level must also be passionate, visionary, engaging, and directive. Build buy-in by creating a pathway (using existing tools) for providers to succeed and by building early champions who can then join the effort to spread this initiative. At every step in the process of implementation, leaders need to continually reconnect the "how" to the "why," and for this reason, successful state leaders should have a personal stake in the game. Consider whether there are existing state priorities that the Zero Suicide approach can be tied to, such as specific health goals or quality improvement initiatives (e.g., reducing hospitalizations or readmissions), health information connectivity plans (e.g., meaningful use of health information), or outcomes required of state contractors (e.g., providers or Managed Care Organizations).

To encourage provider buy-in, consider dedicating discretionary funding to the establishment or augmentation of Electronic Health Records for providers to facilitate fidelity to screening, assessment, and follow up policies.

Additionally, consider providing training for behavioral health staff on specific evidence-based practices and use of validated screening and assessment tools.

> *"Unleashing enthusiasm on the ground is a critical part of moving Zero Suicide forward. Tap into something that generates enthusiasm… Maricopa County, Oklahoma [was] carpet-bombed with CAMS. Do something that inspires people and connects them to one another and to the work. Capture the intellect and the heart of people. Give them an opportunity to face their fear so they can grab onto the excitement."*

As success begins to build and state leadership sees what works in their unique setting, move to a more defined approach with performance targets and payment incentives.

Recommendation: Partner with providers who have the capacity and leadership abilities to stay focused, and can become a champion. Often these are people who have a personal, as well as professional connection to preventing suicide or are passionate about continuously improving clinical care.

As with state-level leadership, finding providers who have a personal *and* professional stake in changing the rate of suicide is a critical component of successful implementation. Begin with providers that have most likely been impacted by death by suicide and/or suicide attempts in order to identify potential champions (e.g., crisis teams, detox or substance use disorder treatment teams, emergency departments). Once these champions are found, support and guide them as they do the initial implementation in their organizations, help them identify strategies to overcome barriers, and track these strategies and successes to share with the organizations that will follow. Consider asking them to present at state meetings and other large stakeholder gatherings to build state-wide support.

Recommendation: Seek dynamic leaders from the survivor community who will partner with you, can tell the story of why Zero Suicide is important and can provide key input into development processes.

In the ongoing effort to build momentum and keep this on the front burner, the role of people who have survived their own suicide attempts or lost loved ones to suicide cannot be underestimated. Their ability to put a face on the issues and to speak openly of the costs of not changing the way we approach people who are struggling can keep momentum going through difficult times in implementation. In addition, their ongoing presence on the implementation team can be invaluable as strategies and approaches are developed; their lived experience can help the team retain perspective.

Recommendation: Partner with other health, education, and justice entities at the state-level to educate about suicide, inform about possible approaches (screening and connecting people to provider organizations and the need for education across the population).

While the data for the Breakthrough Series predominantly focused on those people receiving services in behavioral health organizations, many people who complete suicide are not connected to this system – but they *do* come in contact with primary care systems, schools, and the criminal justice system.

Clinical training on interventions are specifically for behavioral health providers, but the overall approach of Zero Suicide is a public health approach that requires the full participation of other parts of the health care and social service community. At the state-level, this involves connecting with departments of health, Medicaid, MCOs, child-serving systems, and the criminal justice system. In addition, states can build connections with state mortality directors who can then work with their local counterparts to provide critical death data to providers.

Recommendation: Adopt payment policies that supports the Zero Suicide framework including:

- Support provider adoption and augmentation of Electronic Health Records through incentive payments or grant programs.
- Incorporate the Zero Suicide principles into MCO contracts: explore ways to bring MCOs into the Zero Suicide fold. This might occur through writing terms in a contract that includes Zero Suicide approaches as part of an MCOs requirements (e.g. follow up timelines after a crisis episode or inclusion of crisis hotlines or warm lines, or it might include incentive payments for having a network of providers certified as suicide intervention specialists). In other states, state agencies might analyze MCO data for the costs associated with suicide attempts and comparing that to suicide safer care, or Medicaid agencies might adopt suicide safer care as a Performance Improvement Plan for MCOs and compare patterns of death by suicide between different MCOs.
- Payment for care transition activities that support consumers during vulnerable times when moving from inpatient to a home- or community-based setting or after a crisis episode. In 2014, Medicare implemented new payment mechanisms for Transitional Care Management that could serve as a starting point for state and Medicaid programs. Medicare has also started paying for Chronic Care Management services that pays for non-face-to-face services provided to people with two or more chronic health conditions such as depression or heart disease.

Recommendations for Federal Executive Bodies

Recommendation: Extend Medicare and Medicaid reimbursement for meaningful use of Electronic Health Records to psychologists, psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities.

In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act excluded mental health and substance use treatment providers and facilities from receiving funding to enhance care coordination and quality. Most behavioral health providers lack the resources to implement Electronic Health Records. Community mental health and substance use providers face significant financial challenges when trying to adopt comprehensive Electronic Health Record systems, and fewer than 30 percent have successfully implemented full or partial Electronic Health Record systems to date.

Data-driven change processes were universally identified by Breakthrough Series participants as critical to their successful and rapid implementation of components of the Zero Suicide approach. Federal support of the behavioral health field's adoption of Electronic Health Records for care coordination and quality improvement will accelerate adoption of suicide safer care, as well as help the federal government achieve other health system goals that are dependent on a connected continuum of care.

Recommendation: Support additional Zero Suicide Breakthrough Series' learning opportunities.

The Breakthrough Series provided additional lessons regarding implementation of the Zero Suicide approach. As the report indicates, the online toolkit provides a pathway, but state context, organizational culture, data systems, and payment structures are all variables that influence the full implementation of the approach. Providers and states alike universally stated the benefit that the group learning context and focused technical assistance provided them. Six states are further along than they were nine months ago and additional Breakthrough Series' would enable additional states to accelerate their implementation of Zero Suicide.

Recommendations for the Suicide Prevention Resource Center (SPRC)

Recommendation: Explore avenues for in-depth technical assistance for states that have completed the Zero Suicide Academy and show a level of readiness to make significant change (action stage of change). Provide these states and their providers with technical assistance support around data, change process strategy, etc. This technical support needs to be closer to the Breakthrough Series level of support in order to catalyze rapid change and should be closer to 12-18 months in length, focused on the very real world implementation issues and consistent improvement in data collection and change.

Recommendation: Develop a Zero Suicide Academy toolkit that states can use in the development of their own Academies. The toolkit should include PowerPoints, implementation guides and plan templates, process examples and guides, and facilitation guides for state-level leaders.

Recommendation: Initiate focused outreach to the U.S. Health Resources and Services Administration (HRSA) and the National Association for Community Health Centers around Zero Suicide in Federally Qualified Health Centers and Rural Health Centers to explore potential ways to infuse Zero Suicide approaches. This could be facilitated in conjunction with HRSA expansion grant funding for behavioral health. This initial focus with the safety net physical health providers would give SPRC an opportunity to develop a toolkit closely oriented towards primary care in conjunction with advisors who provide primary care. The toolkit could adapt behavioral health provider-based approaches to the primary care context with streamlined approaches and specific recommendations for integrated (primary health-behavioral health providers) and traditional primary care practices.

Recommendation: Develop a focused, concerted outreach to major MCOs to inform them about Zero Suicide approach to care. Partner with state-level providers to assist in gathering case studies about cost data related to suicides that are not completed with recommendations about changes in practice that MCOs can make to assist providers in providing suicide safer care.

CONCLUSION

The Zero Suicide Breakthrough Series set out to identify what critical elements were necessary to bring about suicide safer care. While there is more to be learned and more to be done, leadership, unwavering attention to data, careful development of workforce skills and staying focused on the supports teams need to succeed are major ingredients for success. Driving it all forward are committed state and provider leaders who are committed to making the aspirational goal of zero suicides a reality.

"Implementing Zero Suicide is not a simple task. In reality, it takes a great bit of time, hard work and open-mindedness… In the midst of the journey, keep a name or a face of someone who have been lost to suicide—this will ultimately keep you fueled and passionate about the work… to eradicate suicide."

APPENDIX A: ZERO SUICIDE BREAKTHROUGH SERIES LOGIC MODEL

Zero Suicide Breakthrough Series Evaluation Plan

The Zero Suicide Approach

The National Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. Launched in 2010 by the Secretaries of Health and Human Services and Defense, the Action Alliance envisions a nation free from the tragic event of suicide with a goal of saving 20,000 lives in five years.

One of the priorities of the Action Alliance is to transform health care systems to significantly reduce suicide. The Action Alliance promotes the adoption of "zero suicides" as an organizing goal for clinical systems by providing support for efforts to transform care through leadership, policies, practices, and outcome measurement. This priority builds on the momentum of the 2011 report released by the Action Alliance's Clinical Care and Intervention Task Force, *Suicide Care in Systems Framework*.

Seven essential dimensions have been identified as necessary for health systems to have a comprehensive approach to suicide prevention. These dimensions include:

1. Creating a leadership driven, safety-oriented culture that commits to dramatically reducing suicide among people under care that includes suicide attempt and loss survivors as part of their leadership and planning.
2. Systematically identifying and assessing suicide risk level among people at risk.
3. Ensuring every person has a pathway to care that is both timely and adequate to meet their needs.
4. Developing a competent, confident and caring workforce.
5. Using effective, evidence-based care including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality.
6. Continuing contact and support, especially after acute care and during gaps in care.
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

The Zero Suicide Breakthrough Series

The Breakthrough Series is for states and providers that are currently implementing a Zero Suicide approach. The Breakthrough Series will run from December 2014-September 2015 and will consist of monthly group webinars, bimonthly individual team coaching, and regular data submissions for quality improvement purposes. Six teams to participate; each team will include a state-level governmental agency (the lead applicant) and a provider. We seek to advance implementation of Zero Suicide and to learn what state-level actions support implementation and what provider-level actions facilitate successful improvements in suicide care and implementation of the Zero Suicide approach.

The objectives of the Breakthrough Series are to (a) provide organizations that have already begun to adopt a Zero Suicide approach with the skills and information necessary to advance their effort,

particularly with respect to leadership, screening and appropriate assessment, follow up, and use of a data-driven quality improvement approach to system changes; (b) foster links that support successful change between state agencies and providers that must carry out the changes; (c) determine best practices in providing suicide care for those identified at risk; (d) offer mentorship and support so that the perspectives, knowledge, and skills of each team member inform the work of the other; and (e) develop a set of recommendations and best practices based on the experience and contributions of participants to inform and shape the Zero Suicide effort nationally.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

Evaluation Framework: Zero Suicide Breakthrough Series

Inputs (Resources)	**Activities / Outputs** (Specific Tasks)	**Outcomes** (Impact/Benefits from Activities)
1.1 Six teams of 1 direct health care organizations and 1 state agency 1.2 National Council-coordinated faculty to provide trainings and coaching on strategies for organizational change, data collection and usage, and clinical protocol development. 1.3 SPRC-identified faculty to provide subject matter expertise on dimensions of Zero Suicide approach, including assessment tools and clinical pathways. 1.4 Action Alliance Organizational Self-Study Tool 1.5 Data panel 1.6 Zero Suicide Toolkit 1.7 Data collection instructions	**National Council** 2.01 Provide sites with bimonthly narrative template, data collection tool, instructions, and data dictionary for bimonthly reporting 2.02 Provide bimonthly coaching for each ZS Team, including introductory phone call during first month 2.03 Monthly webinars for all six ZS teams 2.04 Convene bimonthly data-focused discussions that focus on process and outcome measures; to take place during monthly webinars 2.05 In-Person Meeting with all six teams 2.06 Final report that includes recommendations for state executive bodies on how to support adoption of the Zero Suicide approach at the direct point of cares 2.07 Host final webinar to share results with ZS teams and other orgs interested in ZS **Action Alliance** 2.11 Convene data panel for feedback on data collection requirements, review of data materials at mid-point, 2.12 Provide subject matter expertise at monthly webinars dedicated to ZS toolkit topics including screening and assessment tools, pathways to care, continuing contact 2.13 Host in-person meeting in DC in Spring 2015 **Breakthrough Series Teams** 2.21 Participation by recommended staff in webinars, in-person meetings, and telephone-based individual and group calls 2.22 Development and implementation of work plan strategies designed to result in forward progress on self-assessment and sustainability of services 2.23 Completion of organizational self-studies at mid-point and at end of breakthrough meetings (clinical and state) **Clinical Organizations** 2.31 Selection of a standard screening tool for suicide risk 2.32 Selection of a standard comprehensive assessment tool 2.33 Development of agency-wide protocol for addressing suicidality, including screening, assessment and lethal means restrictions 2.34 Development of clinical pathway to care 2.35 Reliably collect and report bimonthly aggregated data to National Council on screenings, assessments, safety plans, attempts, completions 2.36 Use work force training results to guide development of training **State Organizations** 2.41 Reliably report bimonthly to the National Council the barriers and potential solutions 2.42 Develop a change management plan, including communication strategies to advance the implementation of Zero Suicide in their state 2.43 Develop a State-level 12-18 month work plan by end of breakthrough series to support implementation of Zero Suicide	**<u>Short Term</u>** 3.01 Improved scores on Zero Suicide domains on the Organizational Self-Study. 3.02 Increased rate of screening for suicide 3.03 Increased rate of assessment following positive screen for elevated suicide risk 3.04 Increased training on best practices in any or all of the following areas: (treatment, engagement, safety planning, means restriction, warning signs) 3.05 Capacity for providers to report on the number of suicide deaths in population or develop a plan to do so **<u>Medium Term</u>** 3.11 Build policies and protocols for imbedding suicide care practices (to include screening, assessment, safety planning, lethal means counseling, engaging hard to reach clients, care management plans) in a) direct care level and b) state agency level. 3.12 Development of team based and overall lessons learned document. 3.13 Build supports (leadership commitment/dedicated staff) to sustain implementation of ZS. **<u>Long Term</u>** 3.21 Reduction in suicide attempts or re-attempts 3.22 Zero suicides 3.23 Reduced costs to the health care system due to reduced hospitalizations and re-hospitalizations

Measures of Effectiveness

Process & Implementation Questions			
	Logic Model Task	**Question**	**Data Source**
1	2.01, 2.21, 2.41	How many ZS teams submit a complete bi-monthly report?	National Council calendar of activities
2	2.02, 2.21	How many ZS teams attend the bi-monthly coaching calls?	National Council calendar of activities
3	2.03, 2.04, 2.12, 2.21	How many ZS teams attend the monthly webinars about ZS toolkit topics & data discussions?	National Council calendar of activities
4	2.05, 2.13	How many ZS teams attend the face-to-face meeting?	National Council calendar of activities
5	2.06	Was the final report submitted to the Action Alliance useful?	Feedback from Action Alliance
6	2.07	Was the final Breakthrough Series web meeting useful for attendees?	Webinar satisfaction survey
7	2.11	Were there three data panel calls?	National Council calendar of activities
8	2.31	Did each ZS team select a standard screening tool for suicide risk?	Bi-monthly report
9	2.32	Did each ZS team select a standard comprehensive assessment tool?	Bi-monthly report
10	2.33	Did each ZS team develop specific policies for addressing suicidality, including screening, assessment, lethal means restrictions, safety planning, care management expectations, staff training?	Bi-monthly report
11	2.34	Did each ZS team develop a clinical pathway to care?	Bi-monthly report
12	2.35	Did each ZS team reliably collect and report bimonthly aggregated data to National Council on screenings, assessments, safety plans, attempts, completions	Bi-monthly report
13	2.36	Did each ZS team have the work force complete the Work Force Survey?	Work Force survey results
14	2.42	Did each state develop a change management plan to advance ZS in their state?	Change Management Plan
15	2.43	Did each state develop a 12-18 month work plan to support implementation of Zero Suicide beyond the breakthrough series?	Post-Breakthrough Series Work Plan

Outcome Questions			
	Logic Model Task	**Question**	**Data Source**
1	3.01	Did ZS teams improve their score on the Organizational Self-Study?	Pre and post Organizational Self-Study[1]
2	3.02	Did ZS teams increase their rate of screening for suicide?	Bi-monthly report
3	3.03	Did ZS teams increase their rate of assessment following a positive screen for suicide risk?	Bi-monthly report

4	3.04	Did ZS teams receive increased training on best practices in treatment, engagement, safety planning, means restriction and warning signs?	Coaching calls, webinars
5	3.05	Did ZS teams report on the numbers of deaths in the population under care and/or develop a long-term mechanism to do so?	bi-monthly report
6	3.11	Did ZS teams increase understanding of the components and organizational approaches and build policies/protocols for implementing Zero Suicide components that are most effective for impacting care for those at risk of suicide at the direct care and state agency level?	Coaching calls, webinars, in-person meeting, final webinar[2] Documentation of protocols and policies submitted
7	3.12	Did the National Council develop a lessons learned document upon conclusion of the breakthrough series?	Lessons Learned document
8	3.13	Did the states and providers build supports (leadership commitment/dedicated staff) to sustain implementation of Zero Suicide?	Pre and post Organizational Self-Study[1], Bi-monthly report
9	3.11	How did each state choose a provider and help the provider get started?	March 31st breakthrough series meeting
10	3.11, 3.13	How did the state agency demonstrate efforts to address barriers identified by provider organizations?	Bi-monthly report
11	3.11, 3.13	What were the steps for states and providers to implement Zero Suicide?	Coaching calls, final webinar[2]
12	3.21	Did the provider achieve a reduction in suicide attempts or re-attempts?	Post-Breakthrough Series Work Plan[3]
13	3.22	Did ZS teams achieve zero suicides?	Post-Breakthrough Series Work Plan[3]
14	3.23	Did the implementation of Zero Suicide reduce costs to the health care system?	Post-Breakthrough Series Work Plan[3]

[1] – Improvement will be noted on each individual 1-5 scale used in the Organizational Self-Study
[2] – The final webinar will require ZS teams to report back on the policies that they enacted to promote the key components of Zero Suicide.
[3] – The Post-Breakthrough Series Work Plan will include a plan for each state to achieve these outcomes, but the outcomes themselves are not within the scope of this short-term series.

APPENDIX B: MID-POINT MEETING AGENDA

Zero Suicide Breakthrough Series Meeting

Day 1

8:30-9:00am	Registration
9:00-10:00am	The State of Zero Suicide: What have we learned so far? *Mike Hogan and Julie Goldstein*
10:00-10:15am	Break
10:15-12:00pm	Addressing the Cost Question *Virna Little and Becky Stoll* • How do we pay for the actual suicide safer care? • How do we pay for ongoing data analysis of active clients?
12:00-1:15pm	Lunch and Networking
1:15-3:00pm	Addressing the Cost Question
3:00-3:15pm	Break
3:15-4:30pm	Individual Team Meetings and Reporting Out

Day 2

8:30-10:15am	Zero Suicide for the Broader Community: How Do We Reach Out and Incorporate What We Know In the Place Where People Are
10:15-12:00pm	Break
12:00-1:15pm	Lunch
1:15-3:00pm	What Can We Learn From The States and Their Providers?
3:00pm	Adjourn

APPENDIX C: ORGANIZATIONAL WORK PLAN

Creating a leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Implementation team established. Tasks and roles of members clearly defined.					
Announcement of Zero Suicide philosophy to staff and ongoing communication about initiative.					
Consider ways to link Zero Suicide to other initiatives (e.g., trauma-informed care, substance abuse)					
Management training on new initiative (e.g. develop power point for staff trainings).					
Conduct presentation to Board on Zero Suicide, where applicable.					
Budget established to implement Zero Suicide (e.g. purchase screeners, training)					
Review of agency's policies to determine what new policies need to be developed.					
Policies and procedures include review of adverse outcomes related to suicide.					
Policies and procedures include supports provided to staff that have experienced suicide death of a patient.					
Suicide attempt and loss survivors involved in leadership and planning roles.					
Evaluation plan designed to assess impact.					
Hospital environment takes into consideration safety of patients (e.g., break-away rods, door alarms, etc).					

Systematically identifying and assessing suicide risk levels among people at risk: *Screening*					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Policies and procedures describe when clients are screened for suicide risk.					
A validated screening measure is utilized by appropriate staff.					
Suicide risk screenings routinely documented.					
Staff receives formal training on suicide screening.					
Frequency of screening/assessment is outlined.					
Workflows on screening and identification processes established.					

Systematically identifying and assessing suicide risk levels among people at risk: *Assessing and Formulating Risk*					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Facility has a written policy and procedure stating suicide risk assessment is completed during the same visit whenever a client screens positive for suicide risk.					
Facility has a written policy and procedure that clients are provided timely access to clinically trained staff after screening positive for suicide risk.					
A standardized assessment and risk formulation protocol is utilized by all staff.					
All clinical staff receive formal training on risk assessment and formulation.					
Mechanism available to alert all staff who provide care to client about suicide risk.					
Staff understand that information from *screening* (past and present suicide ideation and behavior) is insufficient to formulate risk and inform treatment, and additionally collect the following information to inform risk *formulation*: • *Long-term risk factors* • *Impulsivity/self-control, including substance abuse* • *Identifiable stressors and precipitants* • *Clinical presentation/dynamic factors* • *Client engagement and reliability*					
Risk assessment conducted prior to any less restrictive change in level of observation or discharge.					

Ensuring every person has access to care that is both timely and adequate to meet their needs—This whole section is more suited to outpatient. Tried to make it more inpatient friendly and/or indicate if it should apply to PHP or IOP levels of care.					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Individuals at risk for suicide are placed on a special treatment plan.					
Protocols for indicating that the patient is no longer considered "suicidal" are clear.					
Documentation used by all staff reflects patient status.					
Outreach protocol established for missed appointments for patients in PHP or IOP levels of care.					
Regular team meetings established to discuss patients at risk.					
Coordination of care between all providers for those at highest risk for patients in PHP or IOP.					
Alternatives provided for urgent care (e.g. attempt survivor support groups, drop-in visits).					
A thorough formulation of risk is used to determine management and treatment strategies for each patient's care management plan.					
Risk formulation is updated whenever any aspect of the patient's presentation changes, and on a regular schedule, and should include description of the patient's risk status and risk state, plus coping resources and potential triggers.					

Developing a competent, confident, and caring workforce					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Staff receives training on Zero Suicide philosophy and organization's program and expectations.					
Work force assessed for skills and confidence in providing suicide care.					
Evidence-based training on suicide risk provided for all staff.					
Evidence-based training for suicide care and treatment provided to clinical staff.					
Training is repeated and skills are reassessed periodically.					
Training tailored specific to staff's weaknesses based on work force survey.					
Minimal training for clinical staff should center on information, skills, and confidence in gathering the right information to develop and write a risk formulation, using a standard format across the organization, in the client record and to communicate it to the patient and their support system.					

Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality: Collaborative *safety planning and restriction of access to lethal means*					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Facility's policies regarding suicide care include steps to reduce access to weapons or other potentially lethal means.					
Facility actively and collaboratively engages each patient in their own role of recovery from suicide risk on a routine basis.					
Staff uses same safety planning template across organization.					
Staff receives formal training in safety planning including reducing access to lethal means. Includes periodic refreshers.					
Facility actively engages family or other identified support persons in role of client recovery, including lethal means reduction.					
Training provided to staff around engaging family and other supports in lethal means restriction and safety planning.					

Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality: Effective treatment of suicidality					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
When suicide concerns are present, treatment plan for patient explicitly focuses on reducing suicidality and treating suicide risk directly.					
Fidelity to treatment and outcomes are assessed.					
Policies developed for how to observe patients with suicidal concerns and staff receive training on these policies.					
Routine checks conducted on staff fidelity to the observation policy.					

Continuing contact and support, especially after acute care					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Engagement plan established for patients who are hard to reach.					
Facility has written policies, procedures and/or contracts around safe hand-offs from one level of suicide care to another level, within the facility and with other community based agencies.					
Training provided to staff on client/family engagement and transitions in care.					
Linking/bridging strategies and follow-up tools are consistently utilized and documented (e.g. caring letters, telehealth, text messages).					

Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Targeted goals set for actionable items.					
Measurement for suicide deaths established.					
Data reviewed periodically.					
Work plan updated to reflect results of Work Force Survey and other data outputs.					
Patient satisfaction assessed.					
Work force satisfaction and understanding of Zero Suicide philosophy assessed.					
Fidelity interview conducted by external party.					
Results shared and reviewed with leadership and staff.					

APPENDIX D: BI-MONTHLY REPORT TEMPLATE

Bi-Monthly Report for Zero Suicide Breakthrough Series

State:	
Primary Contact:	

Reporting period:	
Due date:	

		Provider	State
What were your activities to advance Zero Suicide in the last two months?			
Provider barriers & solutions		**Provider Barrier**	**Proposed State /Provider Solution**
	Clinical		
	Organizational		
	Financial		
	Data		
State barriers & solutions		**State Barrier**	**Proposed State Solution**
	Regulatory		
	Budgetary		
	Other		

Provider Questions	Yes/No	Additional Comments/Please describe
Do you have a standard screening tool used for suicide risk?		
Do you have a standard comprehensive assessment tool?		
Has your agency completed the Work Force Survey? When?		

	Do you have a written agency protocol specific to this component of suicide care? (yes/no)	Is this component imbedded in your Electronic Health Record or easily identifiable in your written documentation? (yes/no)	Do you provide staff training specific to this component of suicide care? (yes/no)	Additional Comments
Screening				
Assessment				
Lethal means restriction				
Safety planning				
Care management expectations				

Additional Comments

		Numerator		Denominator		Rate
1	Screening Rate	Number of initial suicide screenings for people enrolled in the reporting period		Number of clients enrolled during the reporting period		
2	Assessment Rate	Number of clients who screened positive for suicide risk and had a comprehensive risk assessment during the reporting period		Number of individuals who screened positive for suicide risk during the reporting period		
3	Weekly Contact Rate	Number of individuals who have had contact every seven days (or less) during the reporting period		Number of individuals enrolled in a Suicide Care Management Plan during the reporting period		
4	Safety Plan Development Rate	Number of individuals with a safety plan developed (same day as screening) during the reporting period		Number of individuals who screened positive for suicide risk during the reporting period		
5	Suicide Deaths	Number of clients who died by suicide during the reporting period		Number of clients enrolled for services during the reporting period (e.g., open case files) regardless of when they were last seen		
6	Missed Appointment Follow-up Rate	Number of individuals with missed appointments who received contact within 12 hours of the appointment during the reporting period		Number of individuals with a Suicide Care Management Plan who missed appointment during the reporting period		
7	Acute Care Transition Rate	Number of individuals contacted within 24 hours of transition during the reporting period		Number of individuals who had a hospitalization or ED admission during the reporting period		

APPENDIX E: GETTING STARTED

Getting Started: for States

1. Use data showing suicide attempts and deaths in the state for those enrolled in mental health care to build champions, galvanize leadership, and build recognition of the need for this focus in the state.
2. Determine what other state agencies or non-profits in the state are focused on improving suicide and mental health care. Develop partnerships and opportunities for shared resources or grant applications.
3. Whenever possible, maximize initiatives that are already underway and build Zero Suicide into them (e.g., integrated care, wellness, trauma-informed care). Zero Suicide is both a discrete initiative that requires focused attention, while also permeating everything done in a learning health care organization.

> *"Connect the steps of what you were already doing to a system and process, and [identify] a way of collecting and analyzing data to know it's getting done."*

4. Find out what your providers need and want and give it to them where possible (e.g., workforce training, access to real-time vital statistics) with an "ask" in return (e.g., data reporting, learning community participation, etc.).
5. Give a couple options for things that will eventually be required, such as a specific kind of training, screening tools, and data reporting.
6. Provide vision and concrete help. Lead a Zero Suicide Academy with a specific post-Academy plan. How will people take what they have learned and use it right away? How will organizational leaders identify champions and then connect them to other champions for their ongoing development? Plan early as all Academies must be done in conjunction with SPRC. Consider that the Academy is only one strategy in overall support for health care agencies implementing Zero Suicide in the state. Other supports might include a Learning Collaborative, billing recommendations, resources pertinent to state-based implementation, ongoing technical assistance by state leaders.
7. Develop learning communities with technical assistance for organizations implementing Zero Suicide approaches. Include open sharing of data as part of this process.
8. Work with payers in your state to get Zero Suicide practices reimbursed.
9. Have patience. Consider that your first year is likely a year to gather data, build champions and elicit energy for pilot sites. It's a marathon, not a sprint.

Getting Started: for Providers

1. Create an implementation team. The team should be diverse comprised of leadership, people with lived experience, evaluators, various disciplines, and be committed to a long-term process.
2. As a team, complete the organizational self-study. Then launch the Zero Suicide Workforce Survey. Share the results of both surveys. This data will "make it real" for your staff and bring the concepts home.
3. Provide training to meet the needs identified in the workforce survey and provide supervision to follow up the training and support the implementation of new practices.
4. Enlist people who have survived an attempt and family members who have experienced suicide loss in your planning and implementation. They provide invaluable guidance and they keep you honest and remind you of why you are doing this. Look at what you are already doing in terms of screening, assessment and clinical care and build your pathway on top of what you are already doing right. The more you can build changes into existing processes the less it will feel like additional work.
5. Educate everyone in your organization about Zero Suicide. If the policy makers and quality improvement staff do not understand it, they won't be able to make the policies align with your approach.
6. Continue at every turn to remind people of the why we are doing this. Remind them that this effort not only will save lives but it improves the overall care for everyone.
7. Establish an internal team of champions who will lead the initiative, who will look at the data regularly and have the power and authority to implement rapid cycle change processes.
8. Use data to determine if your approaches are working in both the short- and long-term. Are you reducing readmissions to the hospital? Are you reducing suicide attempts? Are you increasing assessment rates after screening? Are you talking about lethal means with every single patient? Use your evaluators, staff meetings, and your own patients to better understand your weaknesses and gaps and do continuous quality improvement.
9. Help providers understand how to get paid for the work they are doing. The care that is provided in this approach is good clinical care and reimbursable. In situations where managed care is denying needed frequency of visits, provide a mechanism for support for the provider and advocacy with the managed care organization.