
SOMETIMES THE
HARDEST THING AND THE
RIGHT THING ARE THE SAME.
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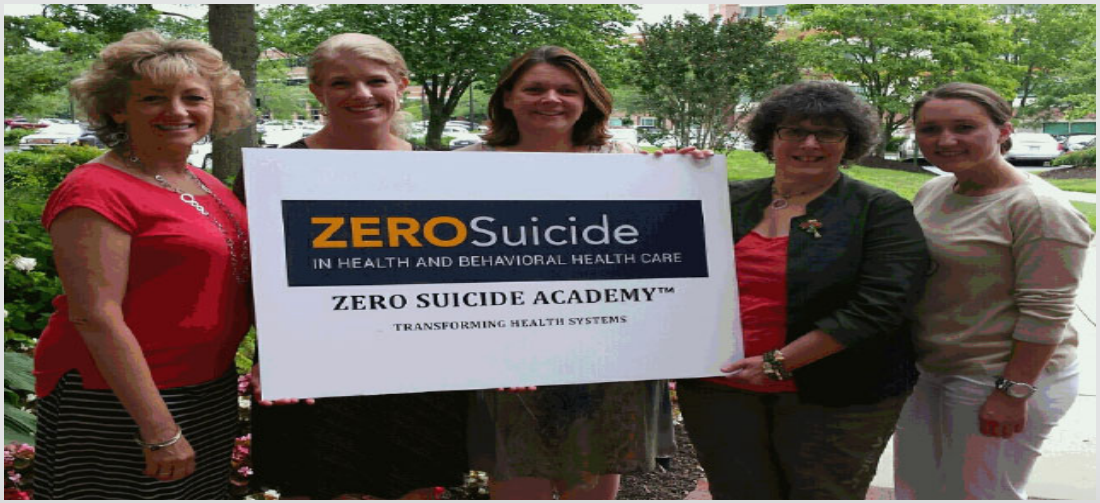
CT Learning Community for ZERO Suicide IN HEALTH AND BEHAVIORAL HEALTH CARE

Andrea Duarte, Patricia Graham, Nancy Hubbard, Elly Stout
CT Suicide Advisory Board
AFRC, Middletown, CT
October 8, 2015

CHA CONNECTICUT HOSPITAL ASSOCIATION

Share our Journey



Ellen Blair, Andrea Duarte, Nancy Hubbard, Linda Durst, Patricia Graham
Zero Suicide Academy, Baltimore, MD, June 25, 2015

Objectives for Today

- Describe the Zero Suicide Approach and 7 Key Components
- Discuss the National and CT Initiative and Learning Community

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"Suicide represents a worst case failure in mental health care. We must work to make it a 'never event' in our programs and systems of care."

Dr. Mike Hogan
National Action Alliance for Suicide Prevention

Statistics

In the month before their death by suicide:

- Half saw a general practitioner
- 30% saw a mental health professional

In the 60 days before their death by suicide:

- 10% were seen in an emergency department

"Over the decades, individual (mental health) clinicians have made heroic efforts to save lives… but systems of care have done very little."

Dr. Richard McKeon
SAMHSA

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What is Zero Suicide?

A foundational belief that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.

- A methodology to eliminate suicide and a state of mind that one suicide is too many.
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- A focus on safety and error reduction in healthcare
- A set of best practices and tools for health systems and providers
- It is critically important to design for zero even when it may not be theoretically possible…It's about purposefully aiming for a higher level of performance.

How is Zero Suicide Supported?

- Key concept of the *2012 National Strategy for Suicide Prevention* and *CT State Suicide Prevention Plan 2020*
- Priority of the National Action Alliance for Suicide Prevention and CT Suicide Advisory Board
- Project of the Suicide Prevention Resource Center, multiple health care systems nationwide, and the CT Networks of Care for Suicide Prevention Grant (GLS)
- For more information: http://zerosuicide.sprc.org/

Zero Suicide Culture Saves Lives

Health and behavioral health care organizations have found:

- Elements of this culture can be implemented without additional funding.
- This culture reduces death by suicide.
- Healthcare Systems Using The Zero Suicide Approach:
  - Henry Ford Health System, Detroit, MI
  - Centerstone, Tennessee
  - Catholic University of America, Washington, D.C., David Jobes: Showing early evidence of success with CAMS tool, with progression towards validation of this tool

High Reliability Organization (HRO)

- The Zero Suicide approach lends itself nicely to the high reliability culture of HHC
- HHC has made the commitment to becoming an HRO and reaching zero on several very important outcomes, such as hand washing, bloodstream infections, falls and ventilator-associated pneumonia- *so why not suicide?*
- This is a Joint Commission goal for transforming healthcare.

The Core Elements of Zero Suicide

Elly Stout, MS
October 8, 2015

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Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

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

EDC Learning transforms lives.

www.sprc.org

Substance Abuse and Mental Health Services Administration SAMHSA www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

National Action Alliance for Suicide Prevention

NATIONAL Action Alliance FOR SUICIDE PREVENTION

VISION

The Action Alliance envisions a nation free from the tragic experience of suicide.

MISSION

To advance the NSSP by:

- *Championing* suicide prevention as a national priority
- *Catalyzing* efforts to implement high priority objectives of the NSSP
- *Cultivating* the resources needed to sustain progress

GOAL

To save 20,000 lives in five years

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Elements of Zero Suicide

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A System-Wide Approach Saved Lives: Henry Ford Health System

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Leadership Commitment and Culture Change

- Leadership makes an explicit commitment to reducing suicide deaths among people under care and orients staff to this commitment.
- Persons with lived experience are supported, and participate in program design and delivery.
- Organizational culture focuses on safety of staff as well as persons served; opportunities for dialogue and improvement without blame; and deference to expertise instead of rank.

Screening and Risk Assessment

- Screen specifically for suicide risk, using a standardized screening tool, in any health care population with elevated risk.
- Screening concerns lead to immediate clinical assessment by an appropriately credentialed, "suicidality savvy" clinician.

Safety Planning and Means Restriction

- All persons with suicide risk have a safety plan in hand when they leave care on same day as the assessment.
- Safety planning is collaborative and includes: communication with family members and other caregivers, and regular review and revision of the plan.
- Means restriction is comprehensive, includes family, and confirmation that access to means has been removed.

Employee Assessment and Training

- Employees are assessed for the beliefs, training, and skills needed to care for persons at risk of suicide.

- All employees, clinical and non-clinical, receive suicide prevention training appropriate to their role.

Suicide Care Management Plan

- Design and use a care Suicide Care Management Plan, or pathway to care, that defines care expectations for all persons with suicide risk, to include:
  - Identifying and assessing risk
  - Using effective, evidence-based care
  - Safety planning
  - Continuing contact, engagement, and support

Effective, Evidence-Based Treatment

- Care directly targets and treats suicidality *and* behavioral health disorders using effective, evidence-based treatments.

Follow-up and Engagement

- Persons with suicide risk get timely and assured transitions in care. Providers ensure the transition is completed.

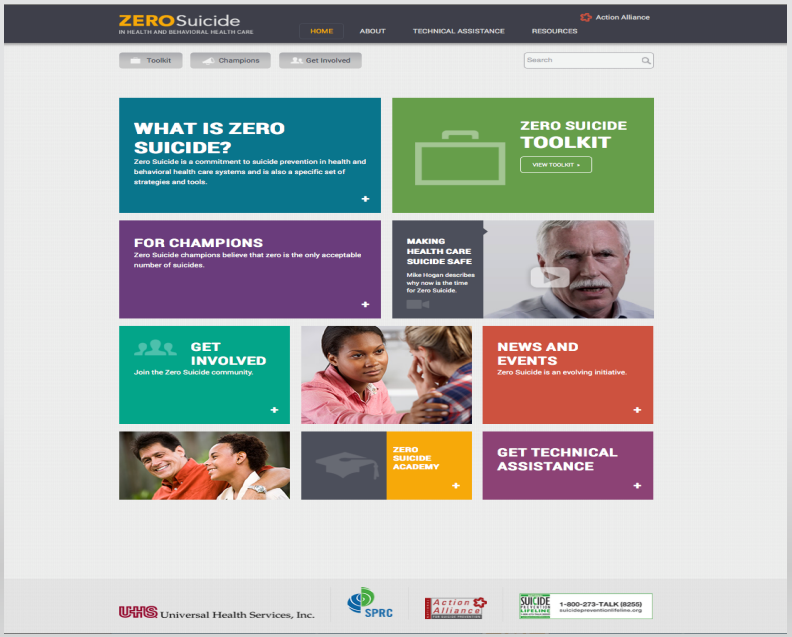
- Persons with suicide risk get personal contact during care and care transitions, with method and timing appropriate to their risk, needs, and preferences.

Quality Improvement and Evaluation

- Suicide deaths for the population under care are measured and reported on.
- Continuous quality improvement is rooted in a Just Safety Culture.

Resources and Tools

www.ZeroSuicide.com



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Contact

Elly Stout, MS
Director of Grantee and State Initiatives
Suicide Prevention Resource Center
Education Development Center
Phone: 617-618-2206
E-mail: **j@edc.org**

Rationale for HealthCare Systems Adopting Zero Suicide

This approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients
- Suicide Care in Behavioral Health Care Settings

Suicide prevention is a core responsibility for behavioral health care systems: Many licensed clinicians are not prepared, 39% report they don't have the skills to engage and assist those at risk for suicide, 44% report they don't have the training.

CTSAB Zero Suicide Learning Community

Purpose: Support adoption of Zero Suicide approach within health and behavioral health systems and beyond their walls to surrounding communities where patients and clients reside ultimately impacting suicidal behavior and death statewide.

System LC Participation WIFM:

- CT and national resources and technical assistance
- System and workforce peer to peer support
- Access to CT and national best practice training resources
- Support to apply for national or CT ZS Academy

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Zero Suicide Initiative: Can Suicide Be A Never Event?

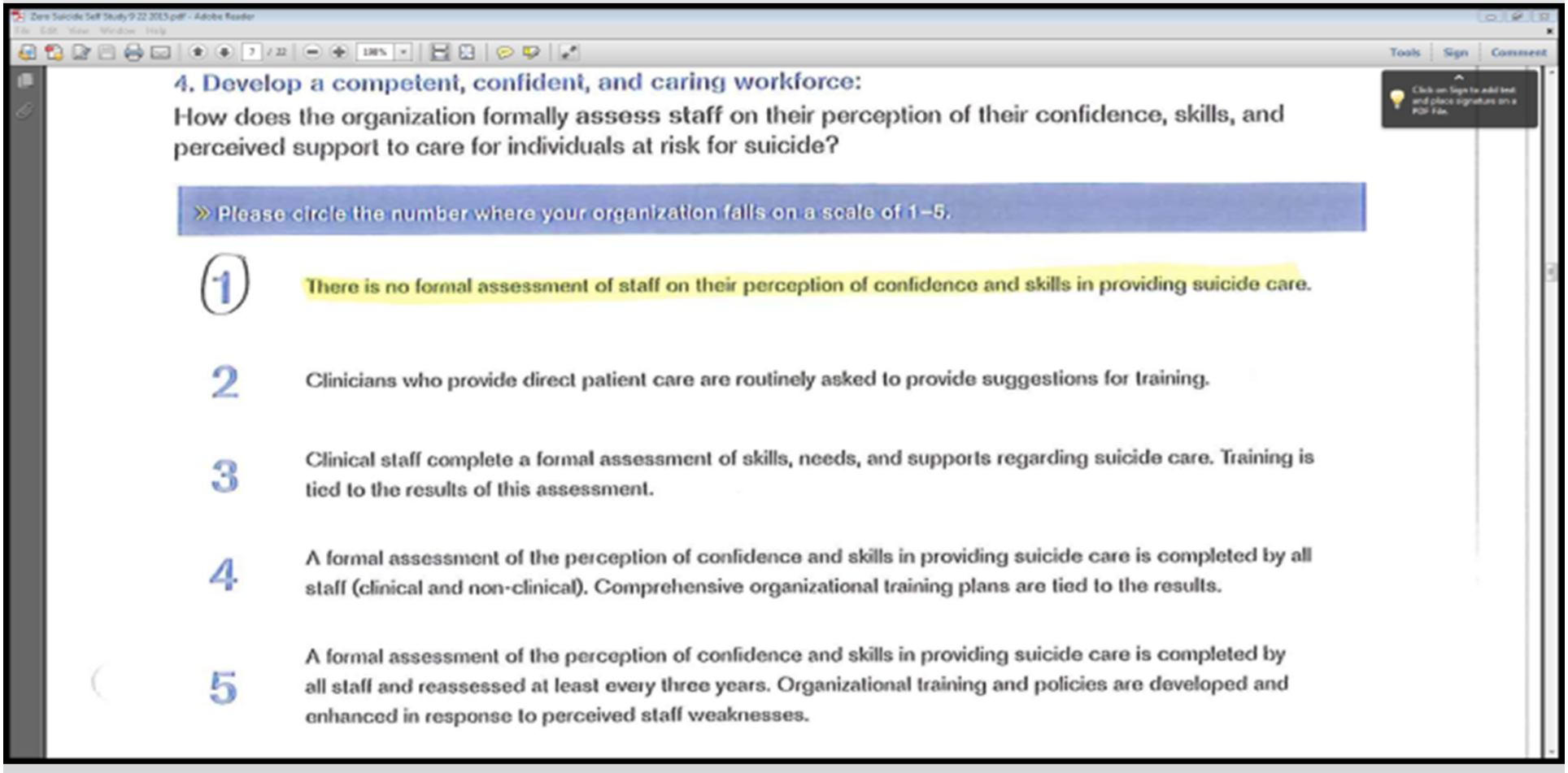
Patricia Graham, Nancy Hubbard
CT Suicide Advisory Board
AFRC, Middletown, CT
October 8, 2015

How did Zero Suicide Academy Begin?

- First ever held on June 2014 for a select group of health care organizations, chosen from multiple applications both national/international.
- Participants learned how to incorporate best and promising practices into their organizations and processes to improve care and safety for those at risk for suicide.
- *Overarching Zero Suicide Philosophy*: Suicide is preventable and health care systems need to embrace and work towards the aspirational goal of preventing ALL suicide deaths for patients in their care. If we don't consider zero suicide a possibility we won't work towards zero.

Applying for Zero Suicide Academy

- Self -assessment and application process
- This presentation is not to criticize our processes now, but to lay ground work, mind set and attitude, a different perspective.



4. Develop a competent, confident, and caring workforce:

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?

» Please circle the number where your organization falls on a scale of 1–5.

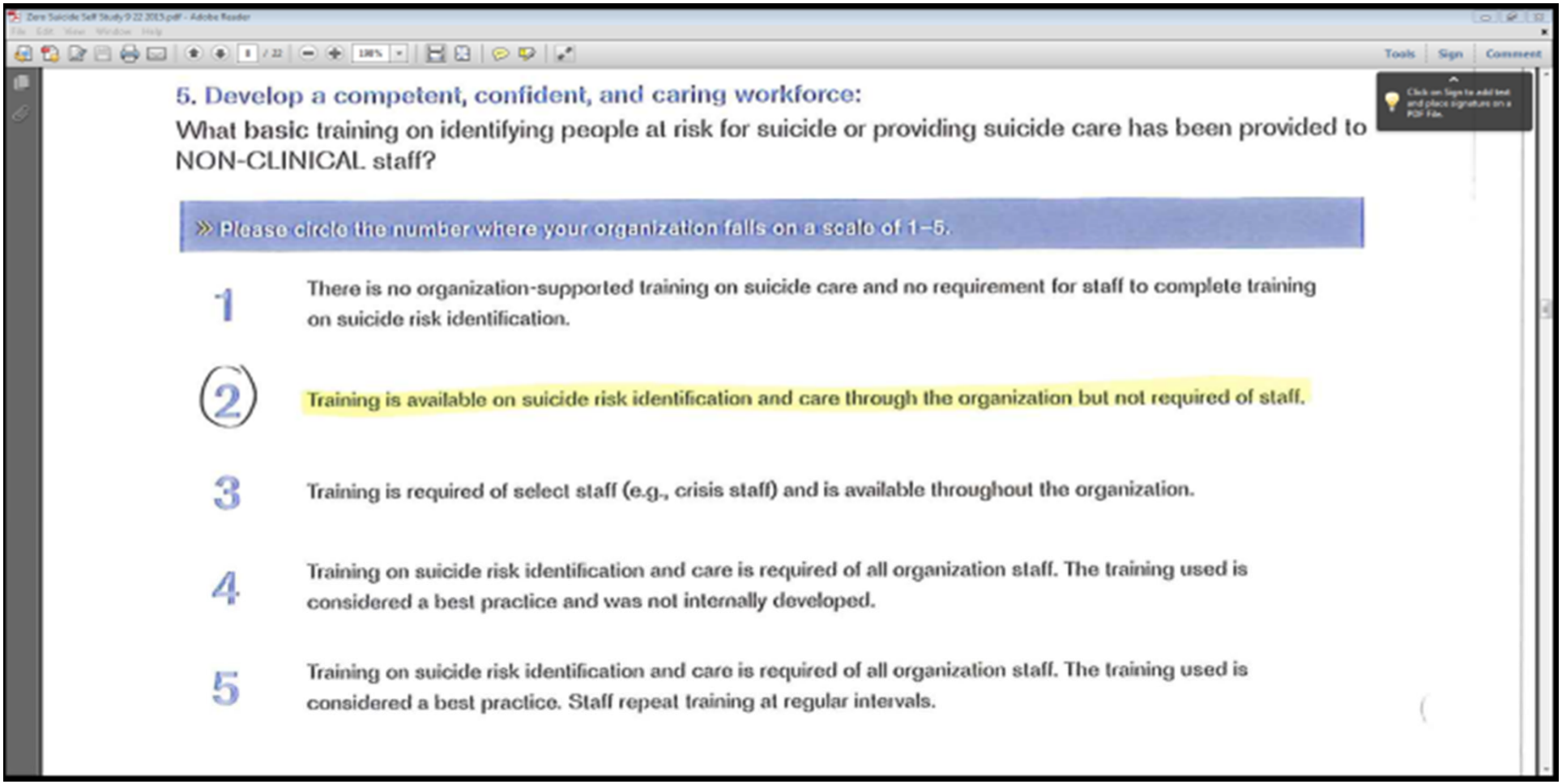
1 There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.

2 Clinicians who provide direct patient care are routinely asked to provide suggestions for training.

3 Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.

4 A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive organizational training plans are tied to the results.

5 A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff and reassessed at least every three years. Organizational training and policies are developed and enhanced in response to perceived staff weaknesses.



5. Develop a competent, confident, and caring workforce:

What basic training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff?

» Please circle the number where your organization falls on a scale of 1–5.

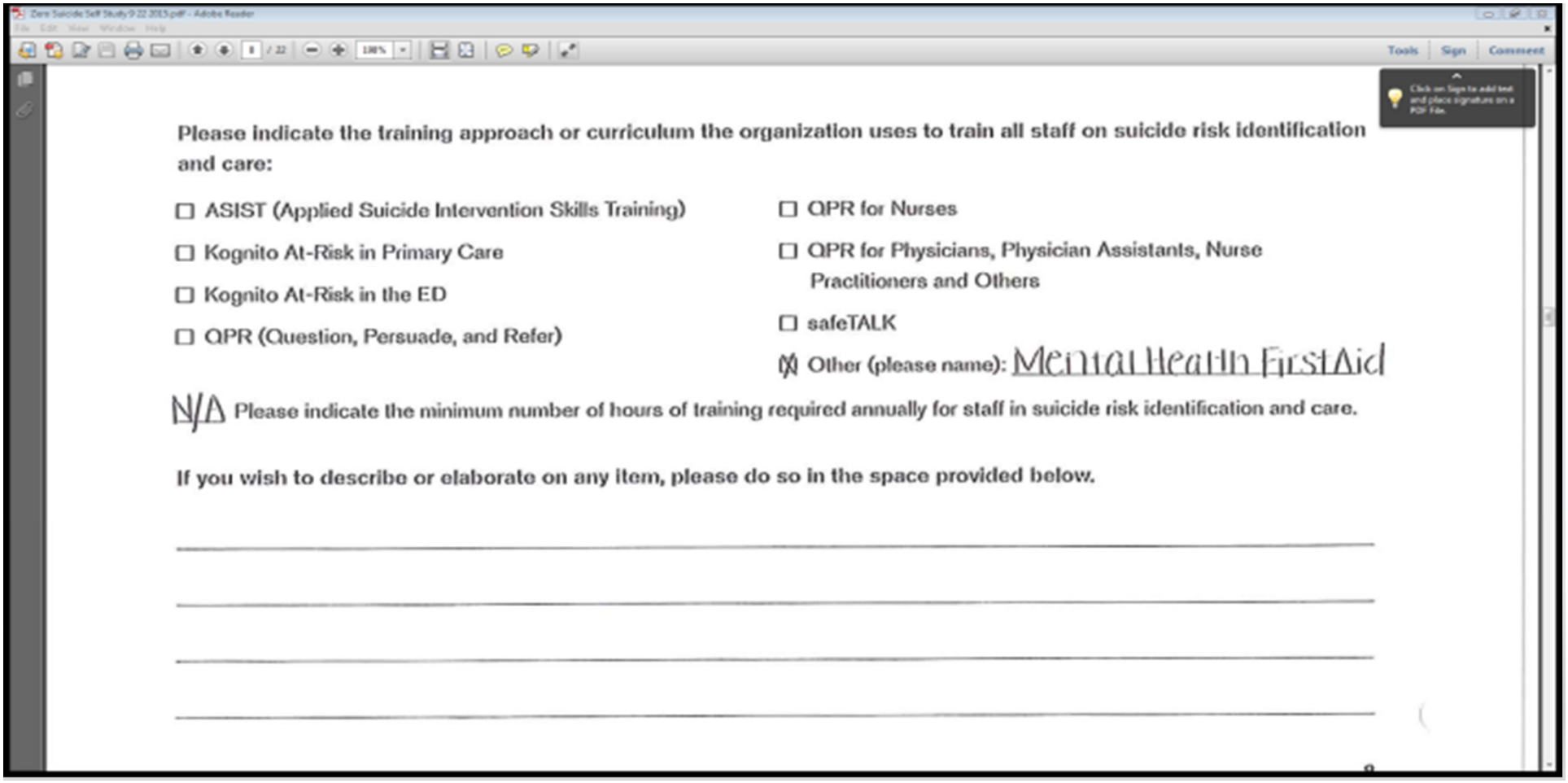
1 There is no organization-supported training on suicide care and no requirement for staff to complete training on suicide risk identification.

(2) Training is available on suicide risk identification and care through the organization but not required of staff.

3 Training is required of select staff (e.g., crisis staff) and is available throughout the organization.

4 Training on suicide risk identification and care is required of all organization staff. The training used is considered a best practice and was not internally developed.

5 Training on suicide risk identification and care is required of all organization staff. The training used is considered a best practice. Staff repeat training at regular intervals.

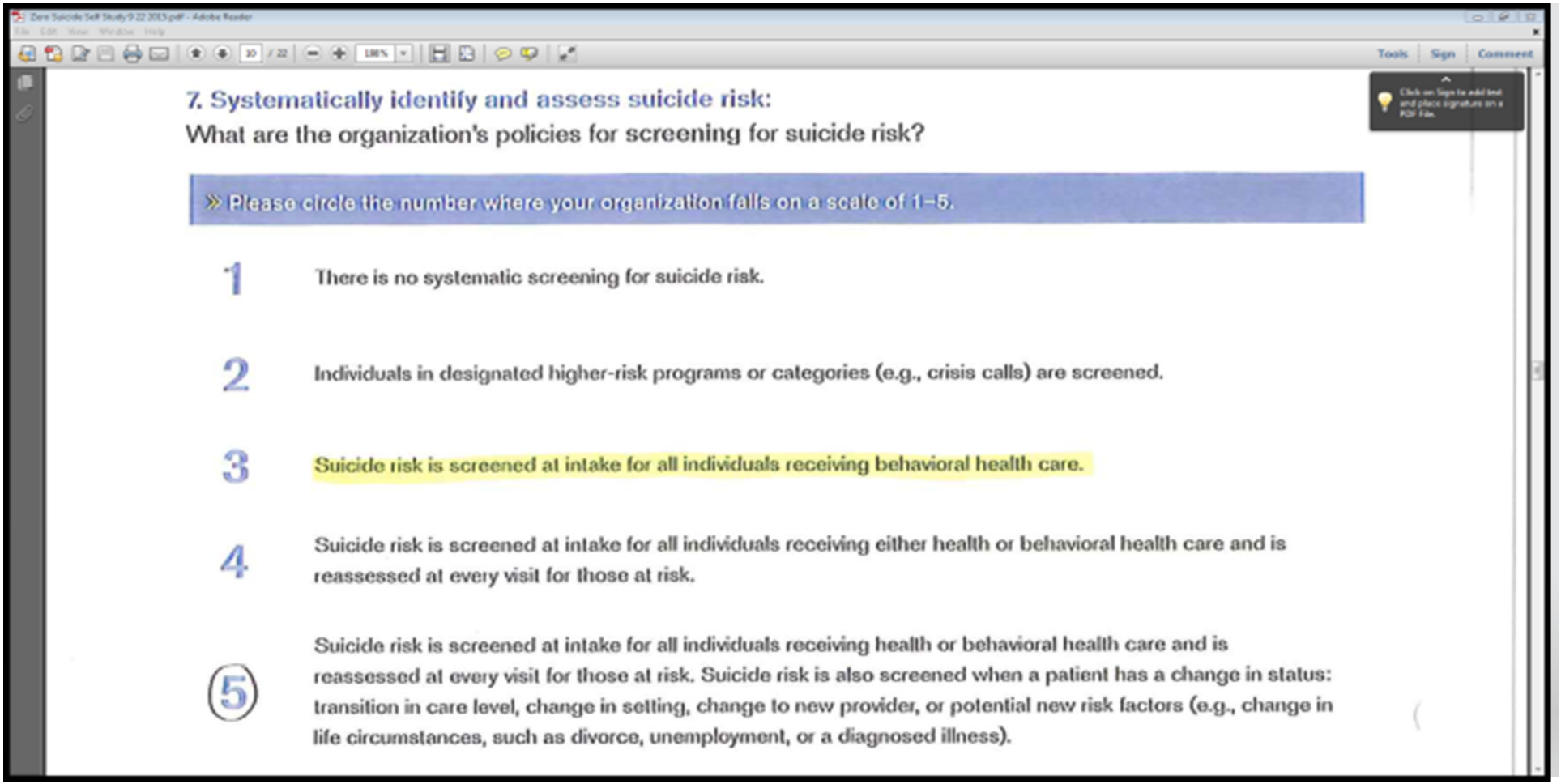


Please indicate the training approach or curriculum the organization uses to train all staff on suicide risk identification and care:

- ☐ ASIST (Applied Suicide Intervention Skills Training)
- ☐ Kognito At-Risk in Primary Care
- ☐ Kognito At-Risk in the ED
- ☐ QPR (Question, Persuade, and Refer)
- ☐ QPR for Nurses
- ☐ QPR for Physicians, Physician Assistants, Nurse Practitioners and Others
- ☐ safeTALK
- ☒ Other (please name): Mental Health First Aid

N/A Please indicate the minimum number of hours of training required annually for staff in suicide risk identification and care.

If you wish to describe or elaborate on any item, please do so in the space provided below.



7. Systematically identify and assess suicide risk:

What are the organization's policies for screening for suicide risk?

» Please circle the number where your organization falls on a scale of 1–5.

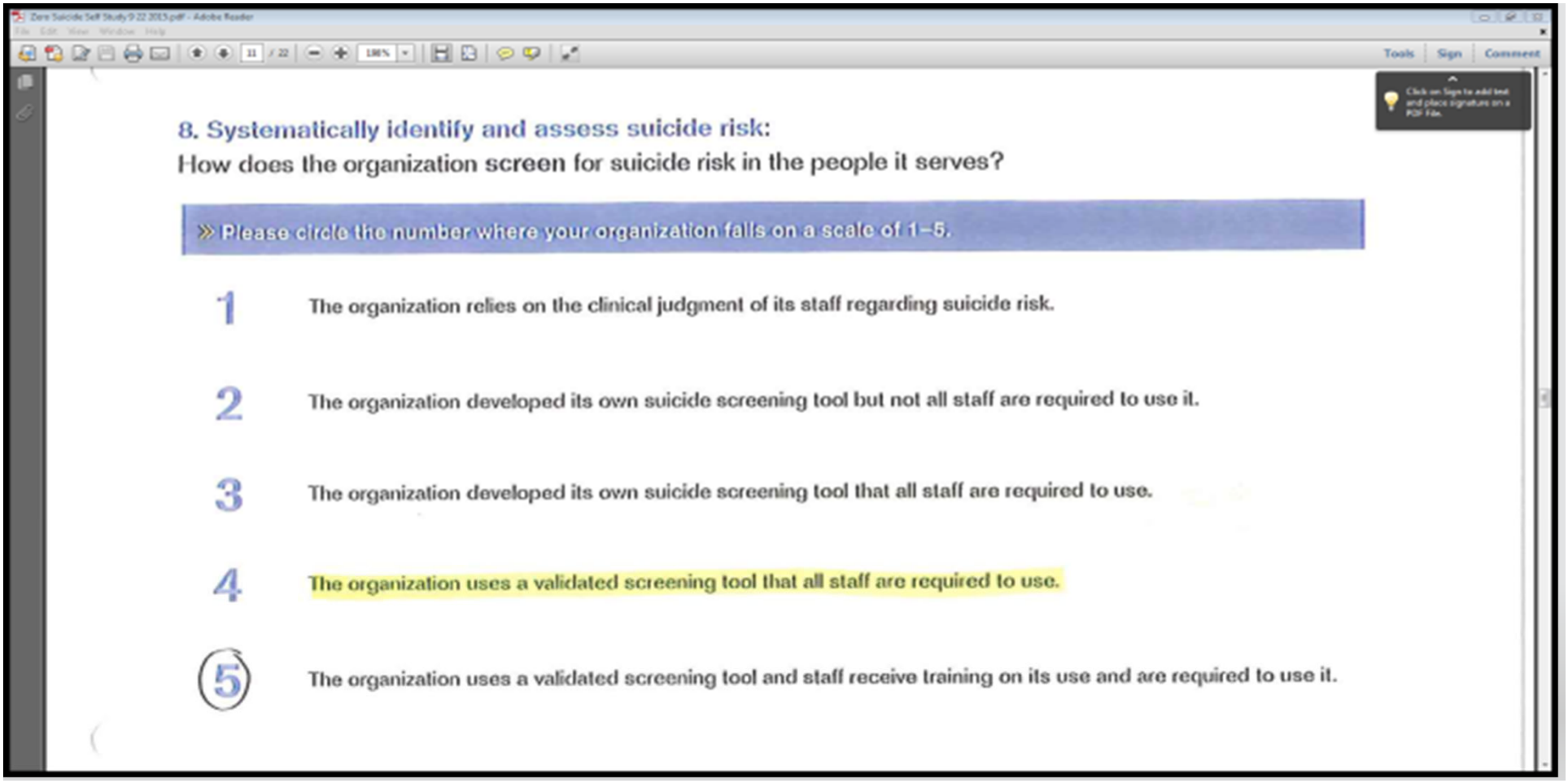
1 There is no systematic screening for suicide risk.

2 Individuals in designated higher-risk programs or categories (e.g., crisis calls) are screened.

3 Suicide risk is screened at intake for all individuals receiving behavioral health care.

4 Suicide risk is screened at intake for all individuals receiving either health or behavioral health care and is reassessed at every visit for those at risk.

5 Suicide risk is screened at intake for all individuals receiving health or behavioral health care and is reassessed at every visit for those at risk. Suicide risk is also screened when a patient has a change in status: transition in care level, change in setting, change to new provider, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).



8. Systematically identify and assess suicide risk:

How does the organization screen for suicide risk in the people it serves?

» Please circle the number where your organization falls on a scale of 1–5.

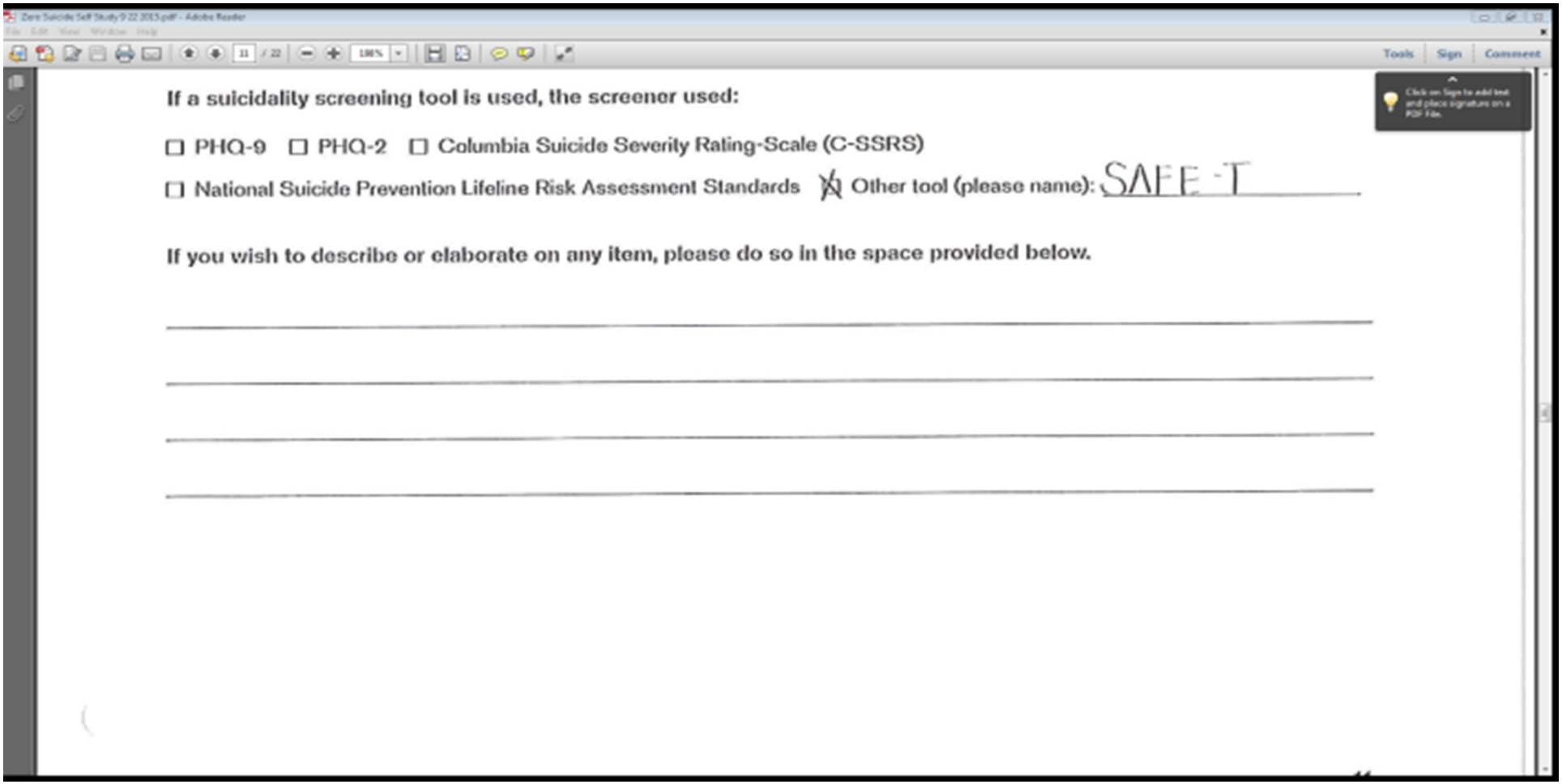
1 The organization relies on the clinical judgment of its staff regarding suicide risk.

2 The organization developed its own suicide screening tool but not all staff are required to use it.

3 The organization developed its own suicide screening tool that all staff are required to use.

4 The organization uses a validated screening tool that all staff are required to use.

5 The organization uses a validated screening tool and staff receive training on its use and are required to use it.



If a suicidality screening tool is used, the screener used:

☐ PHQ-9 ☐ PHQ-2 ☐ Columbia Suicide Severity Rating-Scale (C-SSRS)

☐ National Suicide Prevention Lifeline Risk Assessment Standards ☒ Other tool (please name): SAFE-T

If you wish to describe or elaborate on any item, please do so in the space provided below.

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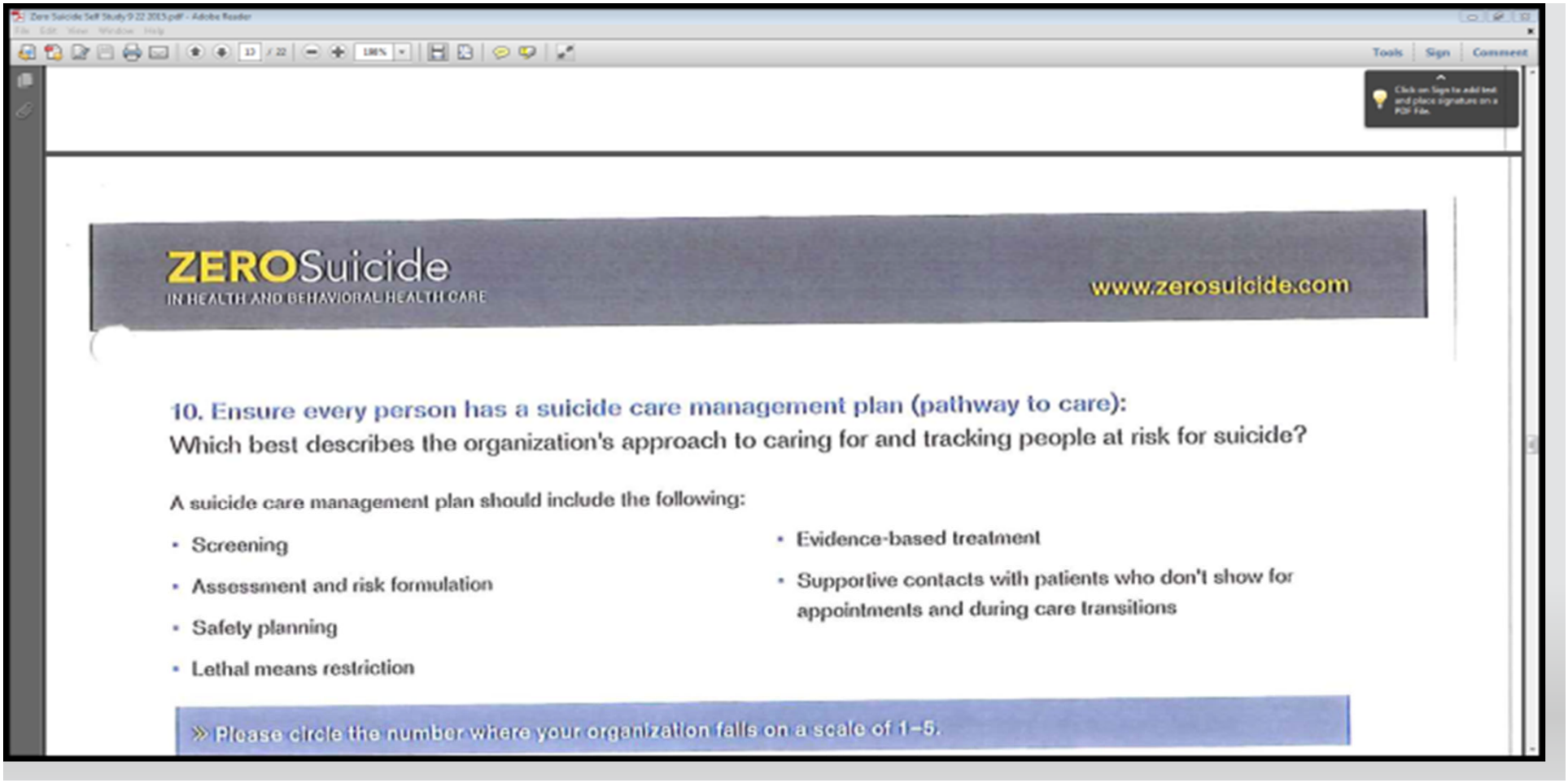

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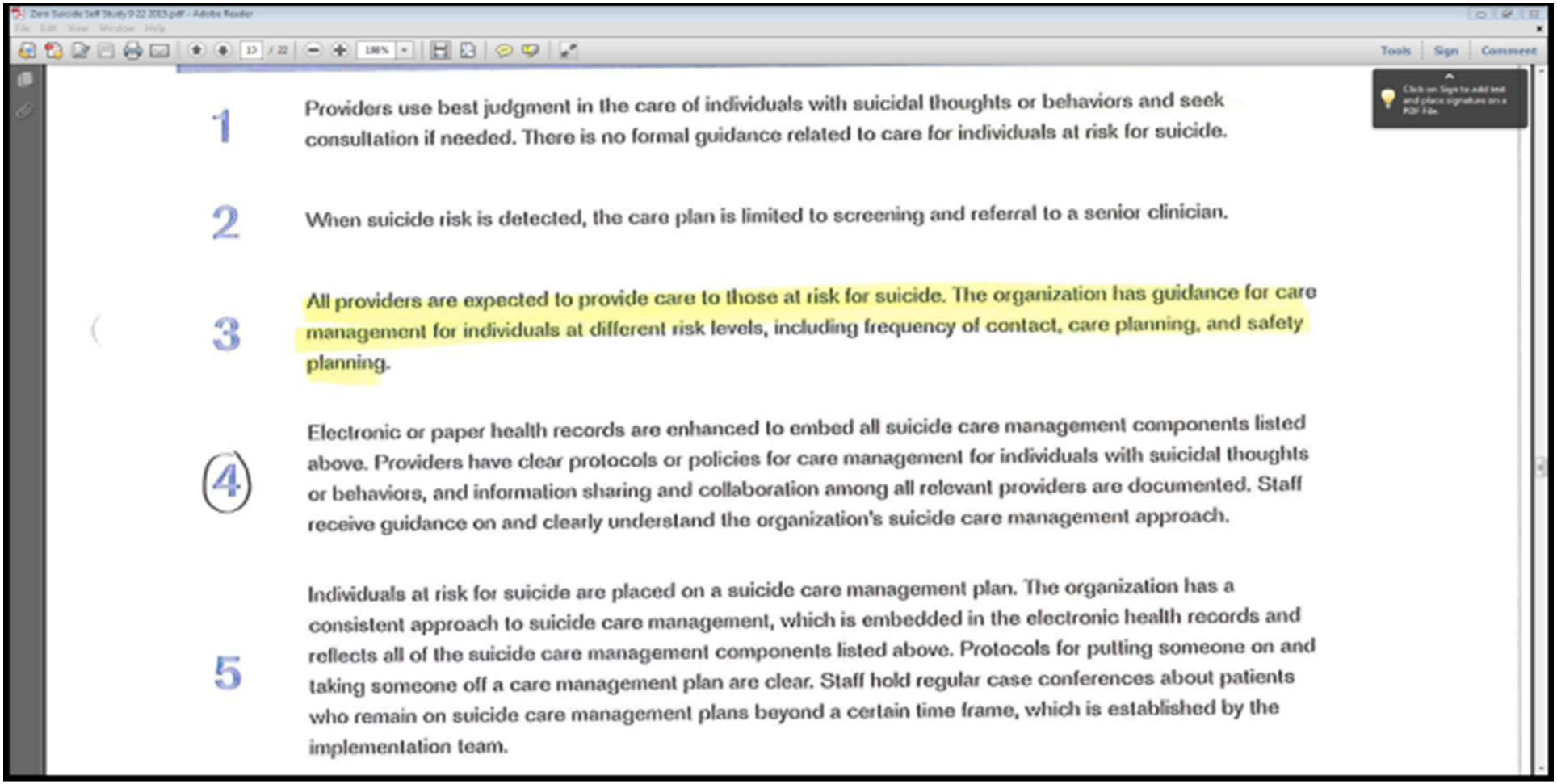


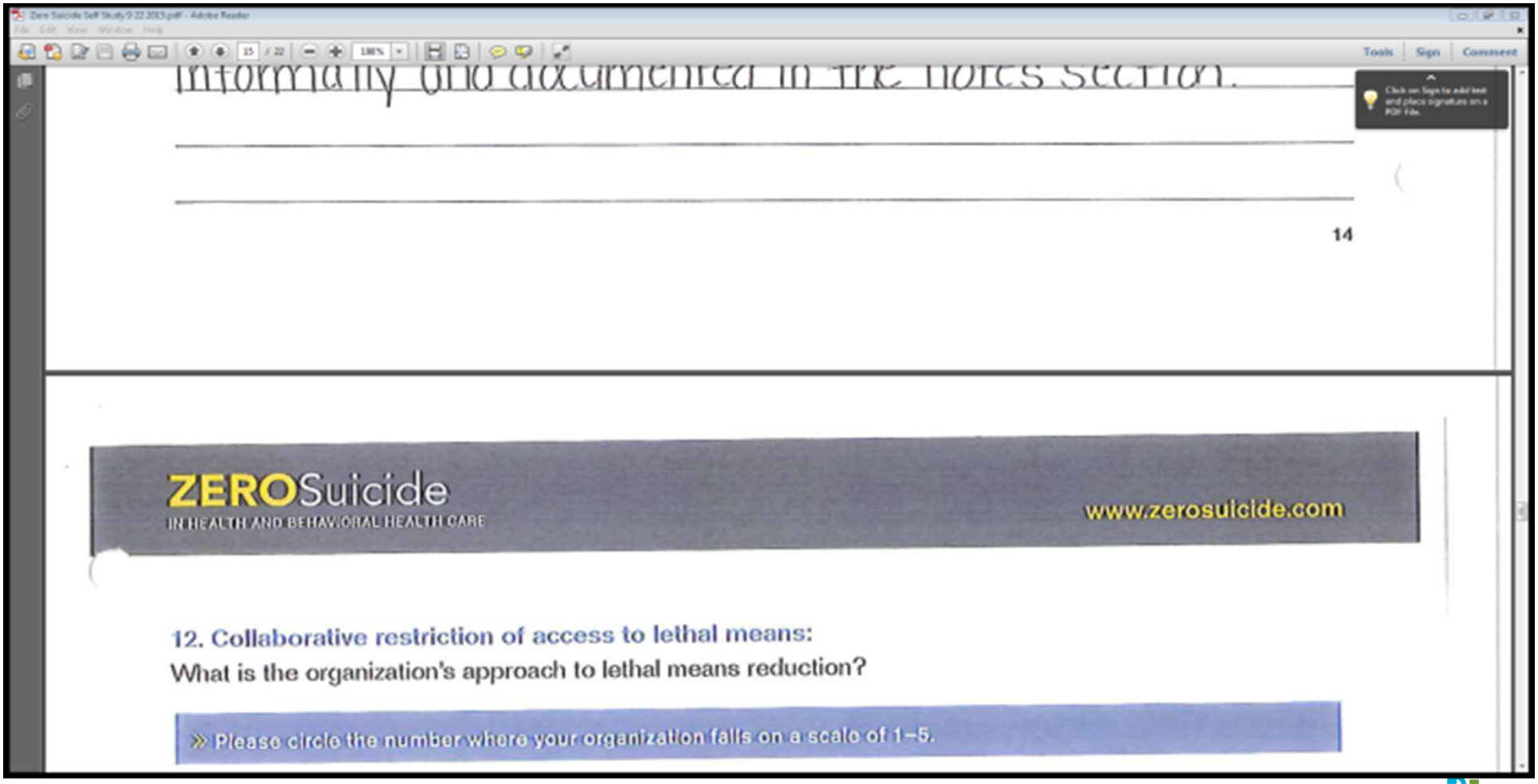
1 Providers use best judgment in the care of individuals with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to care for individuals at risk for suicide.

2 When suicide risk is detected, the care plan is limited to screening and referral to a senior clinician.

3 All providers are expected to provide care to those at risk for suicide. The organization has guidance for care management for individuals at different risk levels, including frequency of contact, care planning, and safety planning.

4 Electronic or paper health records are enhanced to embed all suicide care management components listed above. Providers have clear protocols or policies for care management for individuals with suicidal thoughts or behaviors, and information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the organization's suicide care management approach.

5 Individuals at risk for suicide are placed on a suicide care management plan. The organization has a consistent approach to suicide care management, which is embedded in the electronic health records and reflects all of the suicide care management components listed above. Protocols for putting someone on and taking someone off a care management plan are clear. Staff hold regular case conferences about patients who remain on suicide care management plans beyond a certain time frame, which is established by the implementation team.



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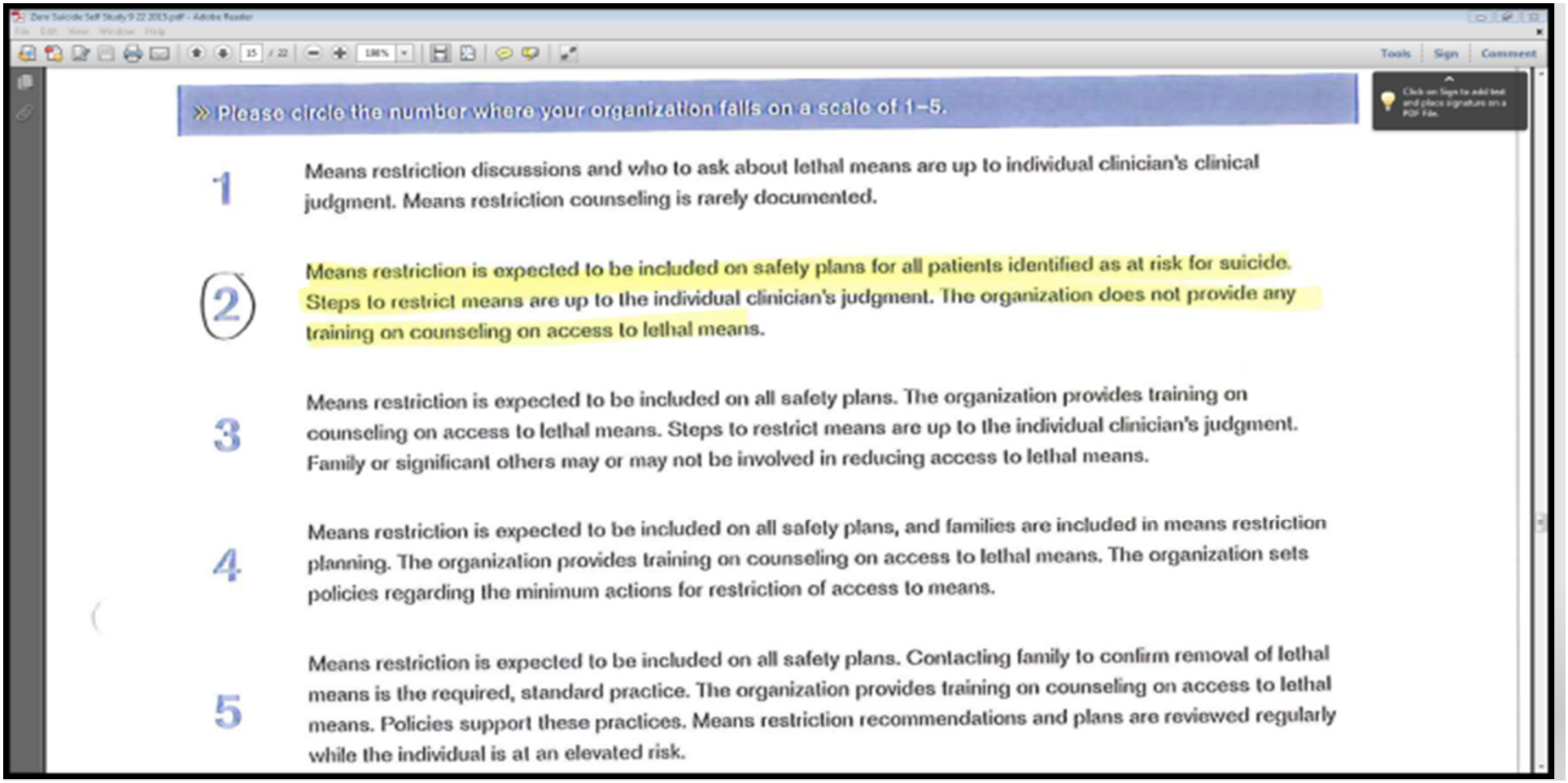


» Please circle the number where your organization falls on a scale of 1–5.

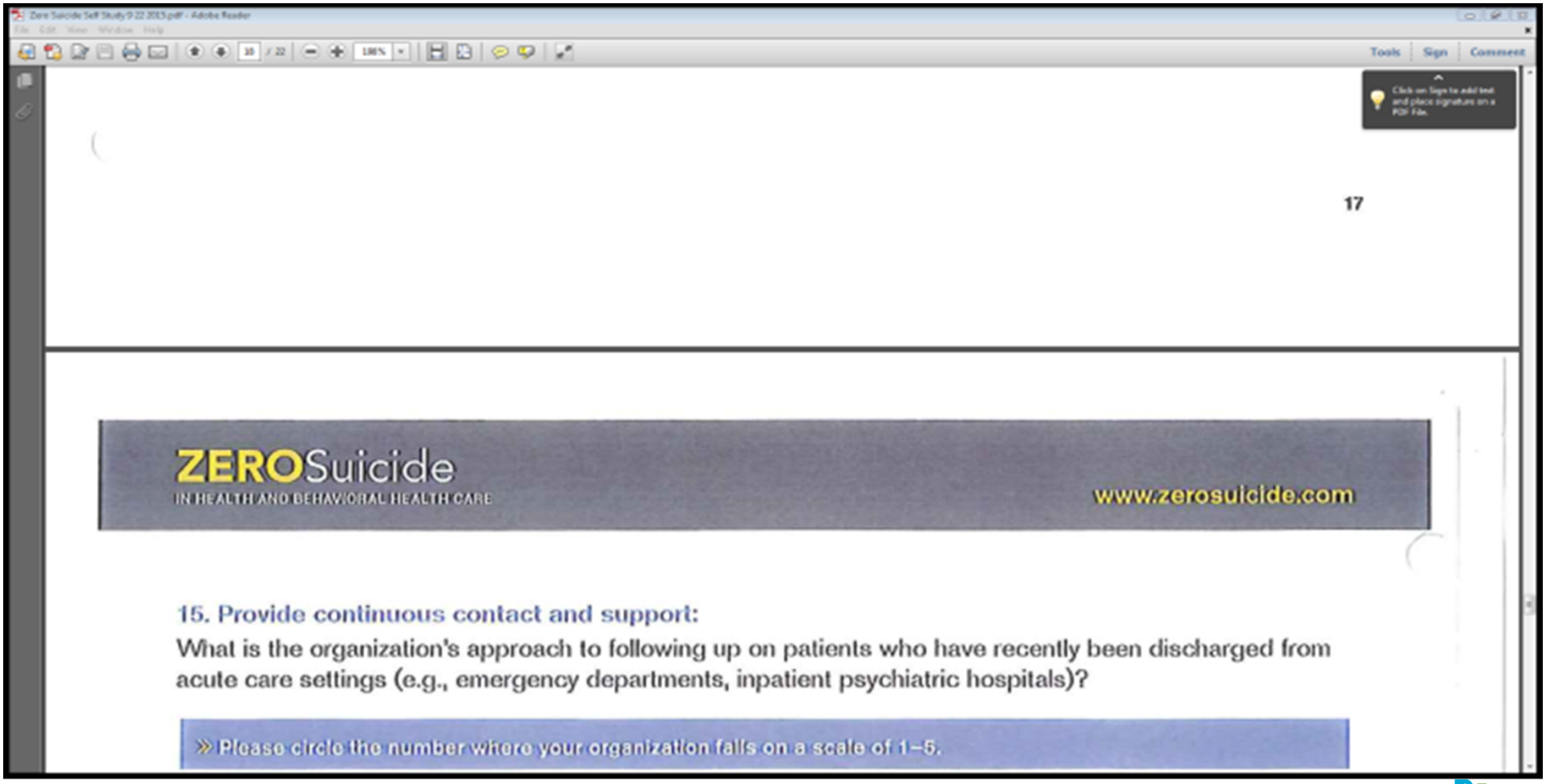
1 Means restriction discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means restriction counseling is rarely documented.

2 Means restriction is expected to be included on safety plans for all patients identified as at risk for suicide. Steps to restrict means are up to the individual clinician's judgment. The organization does not provide any training on counseling on access to lethal means.

3 Means restriction is expected to be included on all safety plans. The organization provides training on counseling on access to lethal means. Steps to restrict means are up to the individual clinician's judgment. Family or significant others may or may not be involved in reducing access to lethal means.

4 Means restriction is expected to be included on all safety plans, and families are included in means restriction planning. The organization provides training on counseling on access to lethal means. The organization sets policies regarding the minimum actions for restriction of access to means.

5 Means restriction is expected to be included on all safety plans. Contacting family to confirm removal of lethal means is the required, standard practice. The organization provides training on counseling on access to lethal means. Policies support these practices. Means restriction recommendations and plans are reviewed regularly while the individual is at an elevated risk.



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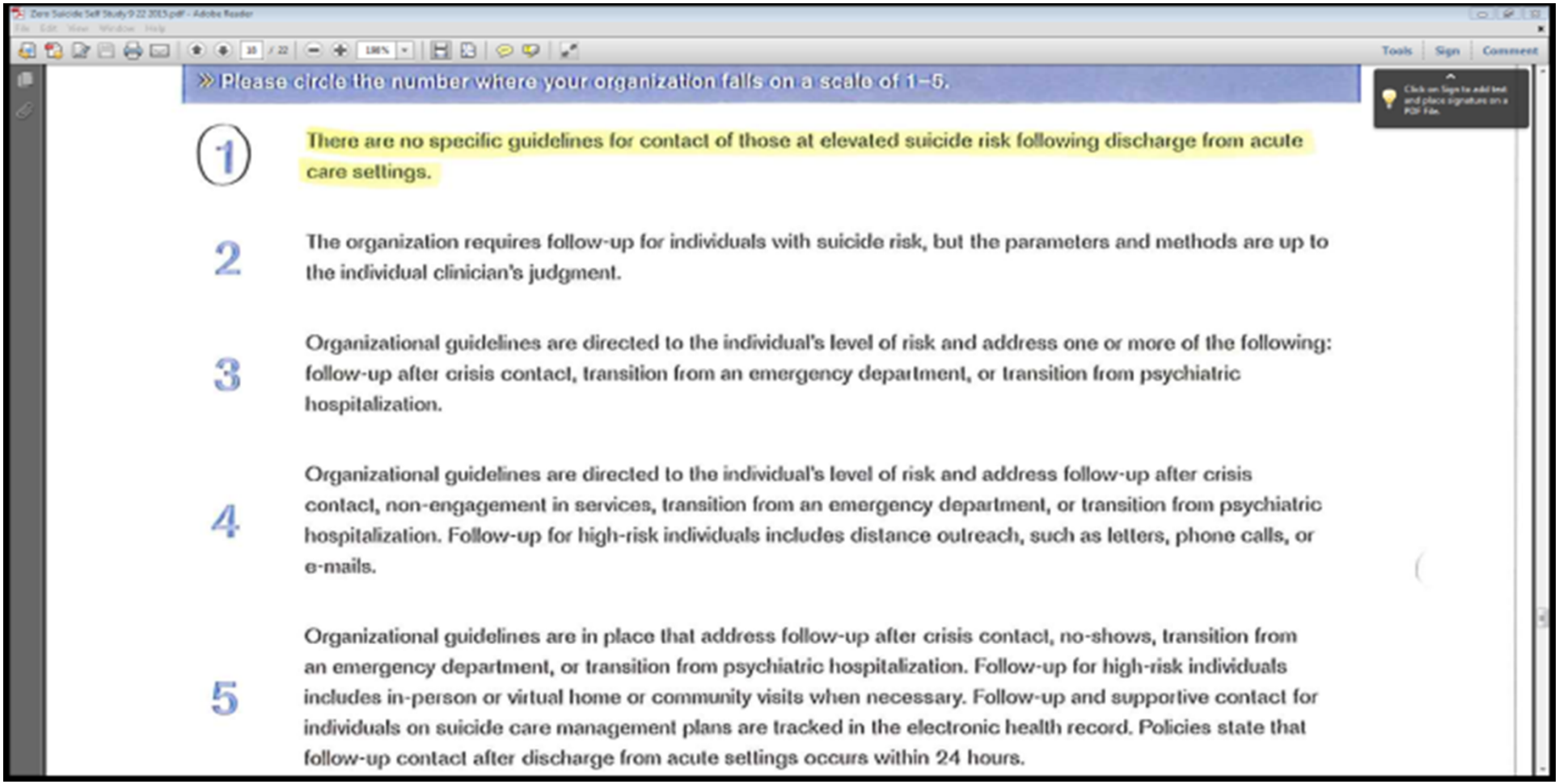


» Please circle the number where your organization falls on a scale of 1–5.

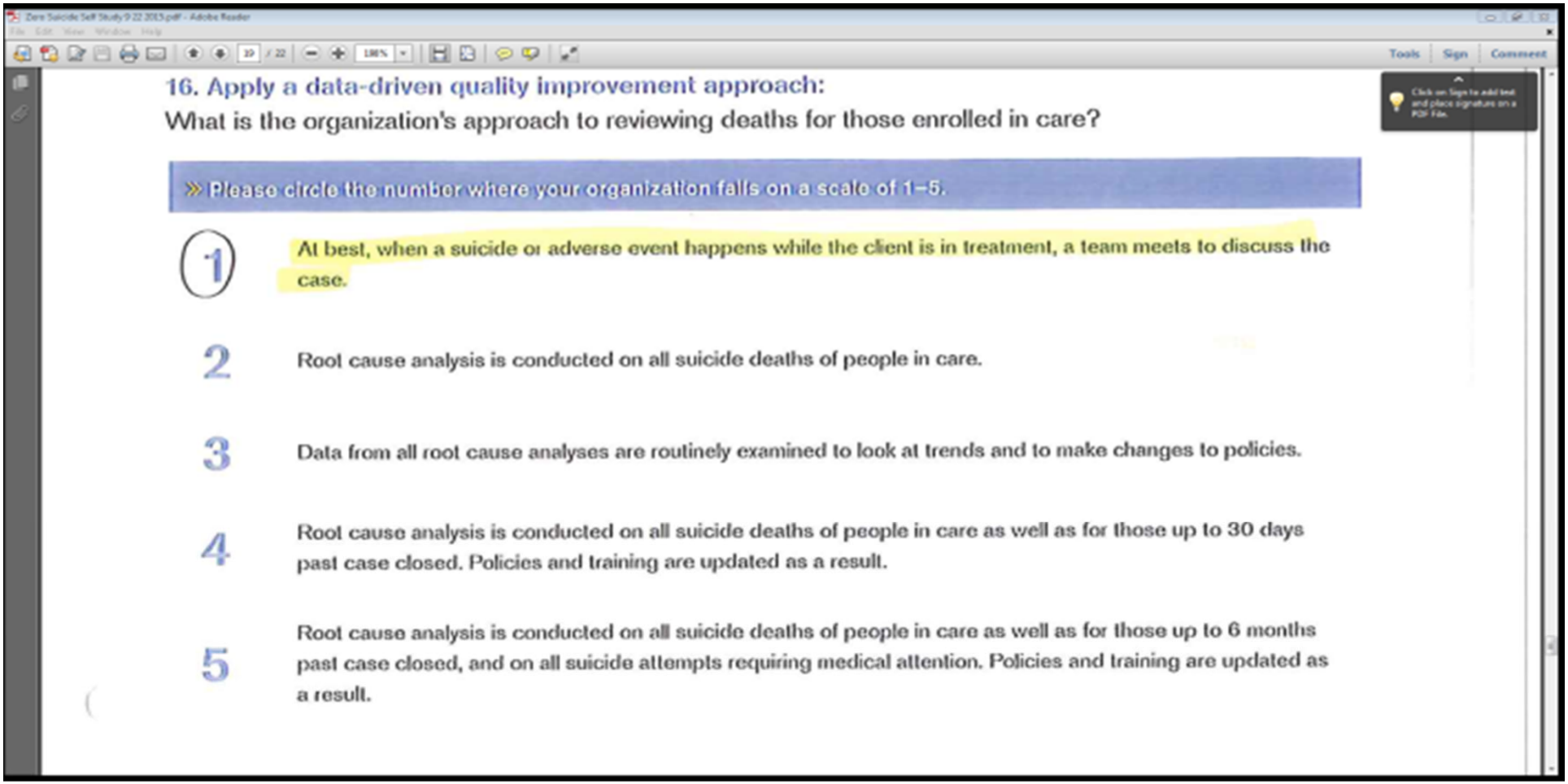
1 There are no specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings.

2 The organization requires follow-up for individuals with suicide risk, but the parameters and methods are up to the individual clinician's judgment.

3 Organizational guidelines are directed to the individual's level of risk and address one or more of the following: follow-up after crisis contact, transition from an emergency department, or transition from psychiatric hospitalization.

4 Organizational guidelines are directed to the individual's level of risk and address follow-up after crisis contact, non-engagement in services, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes distance outreach, such as letters, phone calls, or e-mails.

5 Organizational guidelines are in place that address follow-up after crisis contact, no-shows, transition from an emergency department, or transition from psychiatric hospitalization. Follow-up for high-risk individuals includes in-person or virtual home or community visits when necessary. Follow-up and supportive contact for individuals on suicide care management plans are tracked in the electronic health record. Policies state that follow-up contact after discharge from acute settings occurs within 24 hours.



16. Apply a data-driven quality improvement approach:

What is the organization's approach to reviewing deaths for those enrolled in care?

» Please circle the number where your organization falls on a scale of 1–5.

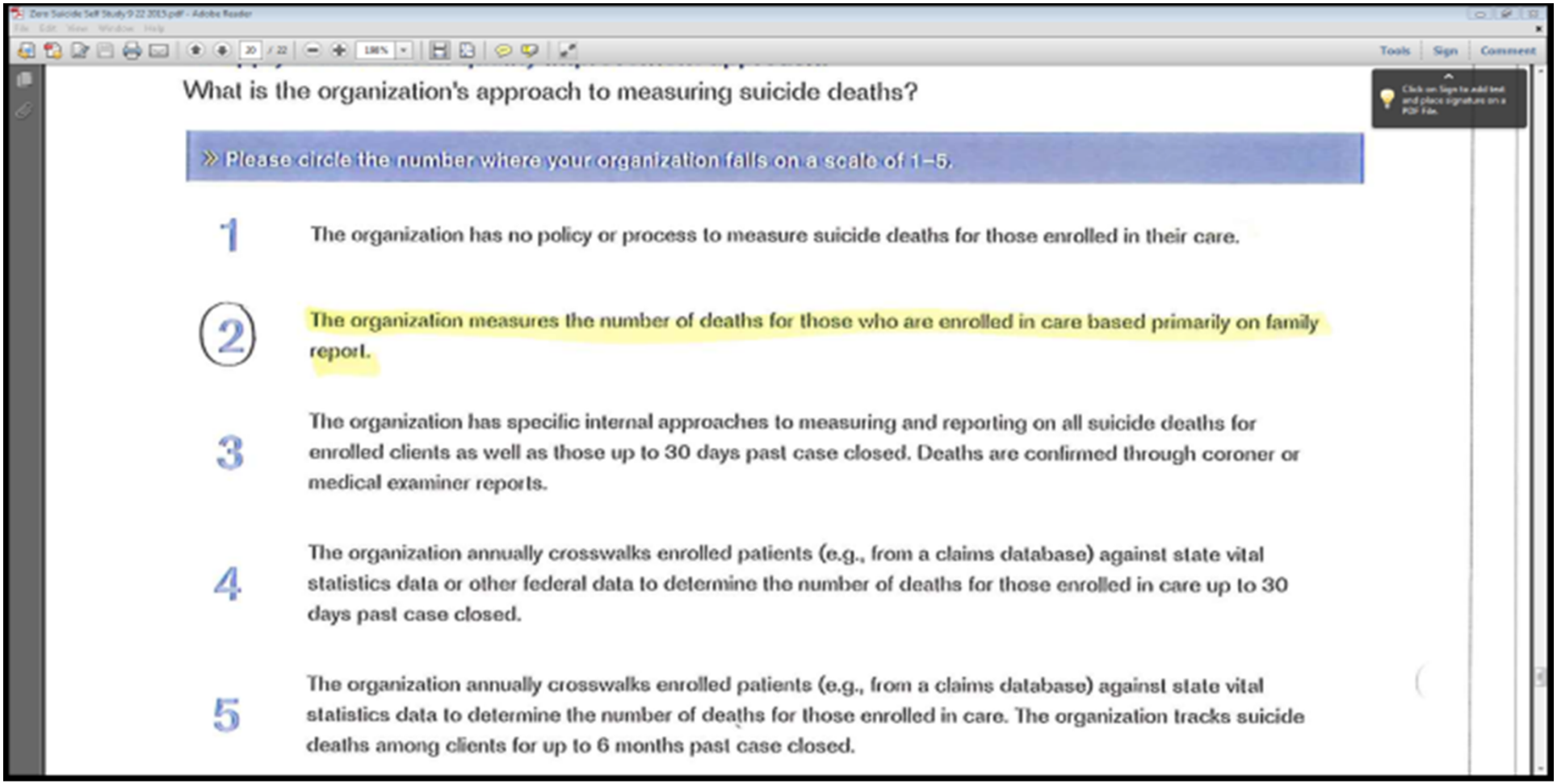
1 At best, when a suicide or adverse event happens while the client is in treatment, a team meets to discuss the case.

2 Root cause analysis is conducted on all suicide deaths of people in care.

3 Data from all root cause analyses are routinely examined to look at trends and to make changes to policies.

4 Root cause analysis is conducted on all suicide deaths of people in care as well as for those up to 30 days past case closed. Policies and training are updated as a result.

5 Root cause analysis is conducted on all suicide deaths of people in care as well as for those up to 6 months past case closed, and on all suicide attempts requiring medical attention. Policies and training are updated as a result.



What is the organization's approach to measuring suicide deaths?

» Please circle the number where your organization falls on a scale of 1–5.

1 The organization has no policy or process to measure suicide deaths for those enrolled in their care.

2 The organization measures the number of deaths for those who are enrolled in care based primarily on family report.

3 The organization has specific internal approaches to measuring and reporting on all suicide deaths for enrolled clients as well as those up to 30 days past case closed. Deaths are confirmed through coroner or medical examiner reports.

4 The organization annually crosswalks enrolled patients (e.g., from a claims database) against state vital statistics data or other federal data to determine the number of deaths for those enrolled in care up to 30 days past case closed.

5 The organization annually crosswalks enrolled patients (e.g., from a claims database) against state vital statistics data to determine the number of deaths for those enrolled in care. The organization tracks suicide deaths among clients for up to 6 months past case closed.

NEXT STEPS

- Letter to organization introducing Zero Suicide
- Organizational assessment, i.e. EMR
- "Low Hanging Fruit" Piloting. i.e., F/U calls on inpt unit
- Anonymous Survey (clinical staff, assess knowledge needs about suicide and suicide assessment)
- ZSAT Champions from each department
- IOL & ED→ HH→ BHN→ HHC
- Project Management