Zero Suicide Toolkit

A set of tools & resources to guide implementation of the Zero Suicide Pathway

Providence | WELL BEING TRUST

VERSION 2, AUGUST 2022

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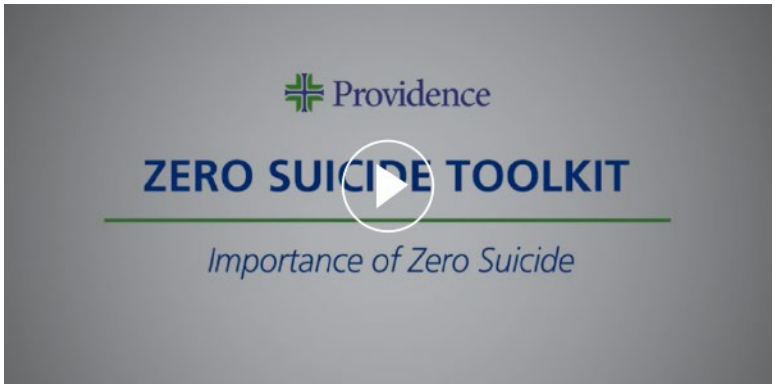
Introduction

The Providence Behavioral Health Leadership Council & Physician Enterprise together are thrilled to present the Zero Suicide Toolkit. The goal of this toolkit is to support clinical teams in all settings to implement highly reliable care to our patients who are experiencing suicidal ideation. The established guidance leverages content created by the multi-disciplinary Providence Zero Suicide Focus Group, and points to materials from national thought leaders, including the Suicide Prevention Resource Center, the Columbia Lighthouse Project and others. These tools are designed to ease your way, while improving the care of your patients.

Why Zero Suicide?

Zero Suicide is a high reliability approach developed originally by Henry Ford Health System in response to the challenge to deliver perfect depression care. In the video below, two of our Providence leaders discuss the importance of this work and why we are seeking to implement Zero Suicide throughout our health care delivery system.

Watch a video message from the Zero Suicide Focus Group Co-chairs: Paul Giger, MD *(Medical Director of Behavioral Health for the Providence Health Plan)*+ **Howard Mun, PharmD** *(Director of Clinical and Quality Governance for Physician Enterprise)*→



How to Approach

While Zero Suicide involves a robust approach involving 7 domains (Lead, Train, Identify, Engage, Treat, Improve & Transition), the primary focus of this Toolkit is the three main areas that constitute the foundational evidence-based care pathway for patients experiencing suicidal ideation: **screening and identification, risk assessment and safety planning.**

The materials enclosed are intended to support the clinical leader to assess the current state, understand the regulatory requirements and how these interventions align, become familiar with clinical standards and develop a plan for implementation.

We recommend first taking account of the current state of operations in your region/ministry/clinic/department. A self-study tool developed by the Zero Suicide Institute is an excellent place to begin understanding the facets of a thorough approach to suicide care, and where your team currently stands. Following the self-study, it may be of value to review regulatory requirements, if applicable to your care environment. Next, you are invited to review the minimum specifications & best practices that have been developed in the Providence Zero Suicide Focus Group, thorough evaluation and analysis by clinicians across the organization. To help guide implementation & improvement, a series of clinical guidance, Epic resources, education and training resources & recommendations, are offered, along with a curated list of external links to additional libraries of resources developed by various reputable organizations and subject matter experts. Finally, a measurement framework is suggested to follow and evaluate progress and impact.

Self-Study & Evaluation

The organizational self-study, developed by the Education Development Center and the Suicide Resource Prevention Center, is intended to provide a baseline assessment of how the process and practices of your clinical team, clinic or facility measure against the standards of Zero Suicide. Here is a link to the online self-study, and a copy is included in Appendix A for convenience. This is a robust tool that measures across all seven domains of Zero Suicide, however, in alignment with this Toolkit, we encourage focus on items 1-6 & 12-17, as they specifically pertain to screening, risk assessment and safety planning.

Regulatory Requirements

Regulatory agencies have given increasing attention to practices and protocols designed to prevent suicide in health care facilities. The Zero Suicide framework promoted in this Toolkit is intended to support your team to satisfy these requirements with sound high reliability practices. For more information on these requirements, you may review the content below:

Joint Commission: Suicide Prevention Recommendations, R3 Report

DNV Acute Care Hospital (pages 127-129): DNV regulations – dnvgl.us/assurance

Providence Minimum Specifications & Best Practices

The enclosed minimum specifications and best practices were created during a series of meetings attended by clinicians and subject matter experts from regions across the Providence family of organizations. They are intended to serve as a guidepost for those who intend to implement highly reliable care for suicidality. Regulatory standards have been considered wherever relevant, and Epic optimization has been sought and implemented as necessary.

The minimum specifications and best practices refer to two evidence-based tools: the Columbia Suicide Severity Rating Scale (C-SSRS) and the Stanley Brown Safety Plan. Each of these is explained in further depth below for reference, with links to original tools and additional information. These are the standardized tools that Providence, as a system, recognizes for assisting patients with suicide risk.

	Columbia Suicide Severity Rating Scale (C-SSRS)	Stanley Brown Safety Plan
Purpose	The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk and gauge the level of support the person needs. **The C-SSRS offers the following:** **Simple.** Ask all the questions in a few moments— with no mental health training required. **Efficient.** Use of the protocol redirects resources to where they're needed most. It reduces unnecessary referrals and interventions by more accurately identifying who needs help — and it makes it easier to correctly identify the level of support a person needs, such as patient safety monitoring procedures, counseling or emergency room care. **Effective.** Real-world experience and data show the protocol has helped prevent suicide. **Evidence-supported.** An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the Columbia Protocol to assess suicide risk, making it the most evidence-based tool of its kind. **Universal.** The Columbia Protocol is suitable for all ages and special populations in different settings and is available in more than 140 country-specific languages.	The Stanley Brown Safety Plan is a proven, evidence-based approach to suicide safety planning. It has been adopted by state health organizations, major health systems including the VA, as well as suicide prevention organizations. Many Providence regions have effectively adopted the Stanley Brown Safety Plan in various clinical areas with great success, patient care efficiency and safety. The use of the Stanley Brown tool meets regulatory and accreditation requirements and is already being utilized in some regions with some Epic functionality to support. **The Stanley Brown Safety Plan offers the following:** A written list of coping strategies and resources to help patients in their times of crisis. Includes elements such as means reduction, problem solving and coping skills, enhancing social support and identifying emergency contacts. A standardized and tangible set of questions to document an agreed upon plan in the event a patient has thoughts of harming themselves. A brief, easy to read format that uses the individual's own words. Can be used as a single session intervention or incorporated into ongoing treatment.

	Free. The protocol and the training on how to use it are available free of charge for use in community and healthcare settings, as well as in federally funded or nonprofit research.	
Population	All	All
Who can administer?	Anyone	Clinicians with a wide range of backgrounds (e.g., nurses, psychologists, primary care physicians, psychiatrists, social workers, pharmacists)
When to use?	BH diagnosis or elevated PHQ-9 screener Reported thoughts about suicide (ideation) What actions they have taken or planned to prepare for suicide Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition	Based on responses of the C-SSRS, a safety plan may be next clinical care intervention needed.
How to use?	Epic build – flowsheet (see link below for details) The caregiver will ask a series of questions about suicidal thoughts and behaviors. The number and choice of questions they ask depend on each person's answers. The questioner marks YES or NO, as well as how recently the thought or behavior occurred and a scoring of its severity. The shortest screeners have two to six questions, depending on the answers, to quickly identify whether a person is at risk and needs assistance.	Epic build – Crisis Safety Plan SmartForm (modeled after the Stanley Brown Safety Plan) (see link below for details) The caregiver will ask a series of questions and document to assist with the recognition of warning signs, employing internal coping strategies, socializing with others who may offer support as well as distraction from a moment of crisis, contacting family members and/or friends, mental health professional or agency contacts, and reducing the potential for use of lethal means.
Components:	6 questions that are answered as YES or NO responses (if yes to question #2, then ask questions 3-6). Use scale to determine guide next steps: Have you wished you were dead or wished you could go to sleep and not wake up? Have you had any actual thoughts of killing yourself? Have you been thinking about how you might do this? Have you had these thoughts and had some intention of acting on them? Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? 6a) Have you done anything, started to do anything, or prepared to do anything to end your life? 6b) If yes to 6a, was this with the past 3 months?	6 steps of questions that are answered by selecting the appropriate response or adding free text: Means Safety Identifying Triggers or Warning Signs Patient led healthy actions to help the patient manage their crisis. Reasons for living Social Supports Crisis Resources
Resource	The Columbia Lighthouse Project Epic Suicide Risk Documentation (C-SSRS)(5/23/2022) (providence.org) *internal-Providence link*	Crisis Safety Plan (7/25/2022) (providence.org) *internal-Providence link* Safety planning guide: A quick guide for clinicians | Suicide Prevention Resource Center (sprc.org) Crisis Safety Plan SmartForm Training

Suicide Screening, Risk Assessment & Safety Planning Minimum Specifications & Best Practices

Primary Care Suicide Screening & Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	PHQ Screening collected for the following patients: • Age 12+ during annual visit, • New patients, • Presenting with mood disorder complaint, or • Have history of depression All patients with a non-zero answer to PHQ item 9 or who endorse suicidal ideation receive CSSRS screener CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project	PHQ Screening collected for patients in accordance with Depression Care Pathway recommendations (LINK) *internal-Providence link*
Risk Assessment	All patients screening positive undergo suicide risk assessment, including risk & protective factors, severity of suicidality, and providing recommendations for potential interventions	
Safety Planning	All patients with a positive (any yes answers) CSSRS screener will develop a safety plan during visit and receive information for local & national crisis lines. *All six steps of the Safety Plan must be completed before it is considered complete*. If all six steps are not completed, the Safety Plan will not be visible to caregiver in other care settings (ED, inpatient, etc.) *A copy should be provided to the patient or patient shown where it is located in MyChart.*	All patients with a positive PHQ-9 item 9 will develop a safety plan during visit, and receive information for local & national crisis lines Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning, next level of care planning, following guidelines based on assessed risk level, which may include involving other individuals and/or health professionals Annual training, including CALM training provided for caregivers

ED Suicide Screening & Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	All patients with a primary BH dx will receive a CSSRS screener CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project	
Risk Assessment	All patients screening positive undergo suicide risk assessment process	
Safety Planning	All patients with a positive (any yes answers) CSSRS will receive a safety plan prior to discharge (whether during ED stay or inpatient admission)	Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning, next level of care planning Annual training, including CALM training provided for caregivers

Inpatient Acute Screening/Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	All patients with a primary BH dx will receive a CSSRS screener (apart from PHQ-4 result) CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project, and provides guidance on 1:1 observation	All patients with a BH dx receive a CSSRS screener
Risk Assessment	All patients who screen positive undergo suicide risk assessment process (performed by psychiatrist, BH clinician or nurse depending on resource availability	
Safety Planning	All patients with a positive (any yes answers) CSSRS will receive a safety plan prior to discharge Documentation on screening, risk assessment & safety plan captured in assessment plan	Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning & next level of care planning Annual training, including CALM training provided for caregivers

Implementation Tools & Resources

As you work toward implementation, we recommend reviewing the resources below. Included are a mix of internally developed content and externally available materials. They are organized by care setting where appropriate and by step of the evidence-based pathway (Screening, Risk Assessment & Safety Planning).

General Materials

Tool	Link	Description
Providence Zero Suicide Pathway Overview	VIDEO (6:45)	Manvi Smith, PsyD, walks through the pathway and offers insights into who can do it and how it can be best done
Keys to Success (SPRC)	LINK	Summary of recommendations
Digital Tools to Consider	Appendix B	Summary of 3 free digital apps that can support patients at risk for suicide

Setting Specific

Care Setting	Tool	Link	Description
Primary Care	Zero Suicide Protocol in Primary Care (Video)	VIDEO (7:28)	Role play between a primary care provider and a patient demonstrating how the protocol is followed
	Recommendations for Primary Care	Appendix C	Document containing recommendations for how to implement the pathway in primary clinics without BH integration
Emergency Department	Zero Suicide Protocol in the Emergency Department	VIDEO (6:45)	Short video summarizing how the protocol is delivered in the ED setting, including Epic workflow **Please note: Epic workflow for the safety plan has changed since the recording of the videos. The SmartPhrase process shown has now been updated to use the Crisis Safety Plan SmartForm, now available in Epic.*

Medical/Surgical Units	Zero Suicide Protocol in the Med/ Surg Environment (Videos)	Medical-Surgical Environment Intro (4:50) Med.Surg.1 - Screening (3:50) Med.Surg.2- Risk Assessment (7:07) Med.Surg.3- Safety Measures (4:35) Med. Surg. 4 Environment- Safety Planning (3:12)	Videos summarizing how the protocol is delivered in the med/surg setting, including a role play with Epic demo **Please note: Epic workflow for the safety plan has changed since the recording of the videos. The SmartPhrase process shown has now been updated to use the Crisis Safety Plan SmartForm, now available in Epic.*

Screening & Risk Assessment

Tool	Link	Description
Providence Epic C-SSRS Screening & Risk Assessment Epic Screenshots & Job Aide	Appendix D	Providence Columbia Suicide Severity Rating Scale (C-SSRS) Epic Build screenshots & tips
Columbia Suicide Severity Rating Scale (C-SSRS)	C-SSRS Screening Tool.docx	7 question suicide screening tool for reference
C-SSRS Training Video	C-SSRS Training (6:07)	Providence training video to aid completion of the C-SSRS with patient
C-SSRS Screening Training Webinar	C-SSRS Screener Training (24:38)	Recorded webinar training
C-SSRS Training Self-Guided Module	Columbia Lighthouse CSSRS Online Training Module	Self-guided online training module (similar to HealthStream)
PHQ Auto-Assignment	PHQ Implementation Toolkit - *internal-Providence link*	Automatically assigning depression screenings to patients prior to their scheduled visit based on specific criteria

Safety Planning

Tool	Link	Description
Epic Crisis Safety Plan Smartform	Appendix E	Safety planning form in Epic
Stanley Brown Safety Planning Tool	LINK	Stanley Brown Safety Plan template for reference
Introduction to Safety Planning Video	Collaborating on Safety Plans | Suicide Prevention Resource Center (sprc.org)	2-min overview of importance of safety planning

Safety Planning Video	Crisis Safety Plan Training (11:37)	Providence training video to aid completion of the safety plan with patient
SAMHSA Slide Show	PowerPoint Presentation (nasmhpd.org)	62 slides Includes scripting
Veteran Population	Safety Plan Treatment Manual to Reduce Suicide Risk: (sprc.org)	Manual with specific recommendations for the Veteran Population
Counseling on Access to Lethal Means (CALM) Training	SPRC - CALM Training Resources PowerPoint Presentation (nasmhpd.org)	Free resources for CALM Training Free, self-paced CALM-Training

Additional Helpful External Resource Libraries:

- Zero Suicide Initiative: LINK
- Columbia Lighthouse Project: LINK

Measurement & Evaluation

Measuring progress is a key to successful implementation. Measuring suicides can be complex due to challenges with data access and timeliness. However, some health care organizations have achieved success by sourcing information from various external parties. Regardless of the ability to measure the outcome of suicide, we recommend measuring the extent to which the evidence-based pathway is followed for patients at risk for suicide. A framework for measurement and evaluation should include (but not necessarily limited to, if your team identifies additional items to capture) the below process metrics, categorized by relevant clinical setting. And as a best practice, scheduled regular review of your data as a team should be done to track progress.

Setting	Metric	Denominator	Numerator
Primary Care	Depression screening rates in primary care (%)	All primary care patients 12 years and older	Primary care patients 12 yrs and older screened for depression (PHQ-2/9, PHQ-A, Edinburgh, GDS)
All	CSSRS Screening Rate (%) (7-question tool)	Patients identified as at risk for suicide: • Primary Care: All patients 12+ with positive PHQ-9 (score 10+) or endorsing suicidal ideation (non-zero item 9) • ER: All patients with a BH-related chief complaint • Med/Surg: All patients with a primary BH dx	Patients receiving CSSRS 7-item tool
ED, Med/ Surg	Suicide Risk Assessment Rate (%)	ED, Med/Surg Patients identified as at risk for suicide (any positive answer on 7-item C-SSRS and/or endorsing suicidal ideation)	Patients who receive comprehensive suicide risk assessment
All	Safety planning rates for positive CSSRS by setting (%)	Patients identified as at risk for suicide (any positive answer on C-SSRS and/or endorsing suicidal ideation)	Patients in denominator who receive a Safety Planning intervention during episode of care, as specified by setting: Primary Care: during visit ED, Med/Surg: prior to discharge to lower level of care

Project Planning Template

Project Overview

It is important to define the purpose & scope of your project. We recommend using a Project Charter and following this framework: Appendix F.

This table provides an easy way to summarize the project:

Project Objectives	Deliverables (Required to satisfy the objectives)	Estimated Timeline
Example: Train all dishwashing staff on how to use the Dishwasher 1000 before retiring the old equipment.	• Posted quick reminder sign in dishwashing area • Dishwashing staff trained on new equipment	Jan 2021

Project Planner

A simple way to track the required steps/tasks to complete the project can be helpful. A sample project planner has been provided below and can be easily built into a table in your preferred program.

Project Planner					
Status	Work Category	Task Description	Owner	Due Date	Notes/ Assumptions
Example: Completed	Training	Develop quick reminder sign	Kitchen Manager- Sally Sue	12/31/20	

Measurement & Evaluation

As a best practice it is important to schedule regular review of your progress as a team. In addition, we would love to share these learnings across the system through the Zero Suicide Focus Group.

Zero Suicide Measurement Framework

Setting	Metric	Denominator	Numerator
Primary Care	**Depression screening rates in primary care (%)**	All primary care patients 12 years and older	Primary care patients 12 yrs and older screened for depression (PHQ- 2/9, PHQ-A, Edinburgh, GDS)
All	**CSSRS Screening Rate (%)** (7-question tool)	Patients identified as a risk for suicide: **Primary Care:** All patients 12+ with positive PHQ-9 (score 10+) or endorsing suicidal ideation (non-zero item 9) **ER:** All patients with a BH-related chief complaint **Med/Surg:** All patients with a primary BH dx	Patients receiving CSSRS 7-item tool
ED, Med/Surg	**Suicide Risk Assessment Rate (%)**	ED, Med/Surg Patients identified as at risk for suicide (any positive answer on 7-item C-SSRS and/or endorsing suicidal ideation)	Patients who receive comprehensive suicide risk assessment
All	**Safety planning rates for positive CSSRS Screening (%)**	Patients identified as at risk for suicide (any positive answer on C-SSRS and/or endorsing suicidal ideation)	Patients in denominator who receive a Safety Planning Intervention during episode of care, as specified by setting: **Primary Care:** during visit **ED, Med/Surg:** prior to discharge to lower level of care

Team Management

As with any new initiative, it is important to define roles & responsibilities of the project team.
Key Roles:

- Local Champion (e.g., nurse or physician leader)
- Sponsor(s) (executive leader or management)
- Project Lead/Process Owner
- Other Key Stakeholders as pertaining to your setting

Communications & Training

Develop a communications plan including all necessary stakeholders. (Sample provided below.) A vital piece to the implementation of this project is training caregivers. You can utilize the communication plan to identify which groups of people need training and in what format.

Communications Plan				
Audience (Who-Receiver)	**Owner (Who-Sender)**	**Timing (When)**	**Format Medium (How/Where?)**	**Purpose (What/Why?)**
Example: Sponsor & Key Sr. Managers	Project Lead	Every 2 weeks on Th. @ 9am	Sponsor Meeting: Room 5	Update the project sponsor on project status & discuss help wanted

Risk & Mitigation

Risk identification and mitigation is a proactive way to approach any project, rather than reacting as barriers arise. By increasing awareness around potential risks and thoughtfully considering a plan, the chances for project success increase.

Risk Register						
#	**Date Raised**	**Description of Risk**	**Impact**	**Risk Level (High, Medium, or Low)**	**Owner**	**Mitigation Plan (Actions to reduce the likelihood)**
1	2/28/21	Example: Trainer is sick & unable to provide training on days arranged.	Training must be rescheduled & delayed implementation	Medium	Clinic Manager	Ensure there are two trainers- one available for backup.

Next Steps - Your Role

ACTION FOR PROVIDERS

Utilize the tools in the pathway to ease your way, increase the quality of care, and improve outcomes for patients.

ACTION FOR REGIONAL LEADERS

Communicate this system pathway practice alert to impacted staff (quality leaders, clinical and operational leaders) to enhance engagement and knowledge of the pathway.

ACTION FOR REGIONAL EDUCATORS

Communicate and educate clinic staff on the use of the pathway and its components.

ACTION FOR CLINIC MANAGERS

Collaborate with regional leaders to advocate for and train all caregivers in their role to meet patient safety goals by utilizing the pathway and its tools.

For questions or more information, please reach out to the Providence Mental Health Strategy Team @ ProvidenceBehavioralHealthLeadershipCouncil@providence.org.

Screening & Safety Planning: FAQ

Roles & Responsibilities

Q- Roles for screening & safety planning

A- PHQ9 and CSSRS can be administered by caregivers and providers. Safety planning has been successfully undertaken by triage nurses, RNCNs, pharmacists, and PCPs.

Q- Is this for PCP and office staff use only or should the behavioral health providers use the Crisis Safety Plan as well?

A- It is for all providers; everyone can use it! It can also be used by BH providers.

Q- Is risk assessment & safety planning out of scope of license?

A- The Columbia Suicide Screener can be completed by any clinician. Although it was designed to be administered by anyone, anywhere, in clinical settings, it is recommended that it is administered by clinical staff. Please refer to your regional and/or clinic policies.

Who Uses It The Columbia Lighthouse Project

About the Protocol The Columbia Lighthouse Project

Similarly for safety planning, it is a quick interactive process that can be carried out by providers.

About the Safety Plan

Q- What is the difference between safety planning & contracting for safety

A- No-harm contracts involve a commitment to what a patient will NOT do in crisis. It is NOT recommended for patient care because there is no evidence that no-harm contracts work. No-harm contracts are not legally enforceable contracts. Making a no-harm contract with a patient endorsing suicidal ideation highlights that a provider believed that the patient posed some level of risk to themselves and simply took the patient's word that the patient would be fine. In conclusion, no harm contracts are clinically ineffective intervention and are a risk and liability issue.

Safety planning on the other hand is an evidence-based intervention that focuses on committing to what a patient will do in crisis or to manage their crisis safely. Safety planning is an intervention that saves lives.

Q- Is the Safety Plan SmartPhrase appropriate for all ages?

A- Pediatrics, teens, adults & geriatric population, as well as other populations (postpartum, veterans, etc)

Q- Is the Crisis Safety Plan available in all clinical care settings?

A- Yes

Q- What about Primary Care sites without Behavioral Health Integration?

A- Safety planning is an intervention that is the standard of care for suicide prevention. This is designed to be done by any provider and does not require any specialized BH training.

Q- How often can/ should we reassess?

A- When working with patients who are at risk for suicide, screening and risk assessment is an integral part of treatment. It guides treatment and monitors patient progress. Based on patient presentation, it is recommended that patients are screened and assessed for suicide risk and safety plans are created, updated, or reviewed as clinically indicated.

Q- Will safety planning add more time and workload?

A- This intervention was designed to be done in a 20-minute Primary Care appointment. As with any new intervention there is a learning curve but as providers use it and become familiar and comfortable with it, it should not add to the time. The Crisis Safety Plan will help with documentation and clinician efficiency all while also providing best evidence-based care to our patients. We recommend switching the agenda of the appointment to addressing suicidal ideation with the patient at the onset of the appointment.

Q- How can we manage risk for both patients and providers?

A- Risk for patients: Safety planning is undertaken for every non-zero response on the PHQ9 or similar screening tool because patient risk can fluctuate over time. Safety planning is an evidence-based intervention that saves lives.

Risk for providers/caregivers: The Crisis Safety Plan aims to standardize care and help guide the interventions providers and caregivers use in addressing suicide risk assessment and safety planning. It also helps with documentation of the care provided.

EPIC | Documentation

Q- Where will the Safety Plan be seen?

A- A crisis safety plan is available in all clinical settings – IP, ED, and Ambulatory. The crisis safety plan smartform data is stored at the patient level and when it is set up in one encounter, it will be made available in other encounters. For example, a Crisis Safety Plan set up in an ED encounter will be available in an Ambulatory encounter on a later date. Any existing Crisis Safety Plan can be later viewed and modified within the smartform activity tool.

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A. Organizational Self-Study

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ZERO SUICIDE ORGANIZATIONAL SELF-STUDY

Name of Organization

City, State

Date Study Completed

Team members completing study:

Name	Role
Name	Role
Name	Role
Name	Role
Name	Role

Background:

The organizational self-study is designed to allow you to assess what components of the comprehensive Zero Suicide approach your organization currently has in place. The self-study can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan. Later in your implementation efforts, the self-study can be used as a fidelity check to determine how closely the components of the Zero Suicide model are being followed and as an opportunity to identify areas for improvement. We recommend taking the self-study at launch and then at 12-month intervals.

Staff involved in the policymaking for and care of patients at risk for suicide should complete the self-study as part of an implementation team. The team should complete this tool together during one of their initial meetings. (Information about putting together a Zero Suicide implementation team can be found on our website.) While the self-study is not exhaustive with regard to all issues that can affect patient care and outcomes, it does reflect components that define the Zero Suicide approach. For more information or clarification regarding any of the items in this self-study, please visit **www.zerosuicide.com**.

Each component of the Zero Suicide model is measured on a rating scale from 1 to 5, described below. The scale is intended to balance minimal reporting burden with measuring implementation for the most essential parts of the model. This tool should be completed by members of the implementation team who are responsible for developing and implementing the organization's Zero Suicide initiative.

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1.11.17

General guide to rating:

Anchors, or specific expectations, are included for most components following this guide.

Rating	Description
1	Routine care or care as usual for this item. The organization has not yet focused specifically on developing or embedding a suicide care approach for this activity.
2	Initial actions toward improvement taken for this item. The organization has taken some preliminary or early steps to focus on improving suicide care.
3	Several steps towards improvement made for this item. The organization has made several steps towards advancing an improved suicide approach.
4	Near comprehensive practices in place for this item. The organization has significantly advanced its suicide care approach.
5	Comprehensive practices in place for this item. The organization has embedded suicide care in its approach and now relies on monitoring and maintenance to ensure sustainability and continuous quality improvement.

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1. Create a leadership-driven, safety-oriented culture:

What type of commitment has leadership made to reduce suicide and provide safer suicide care?

This item refers to the development of formal policies, processes, or guidelines in one or more of the following areas:

- Workforce training
- Suicide screening
- Suicide risk assessment and risk formulation
- Suicide care management plan
- Safety planning
- Lethal means reduction
- Evidence-based treatment
- Contact with patients with known suicide risk who don't show for appointments
- Follow-up with patients with known suicide risk during care transitions or following discharge

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

○	1	The organization has no processes specific to suicide prevention and care, other than what to do when someone mentions suicide during intake or a session.
○	2	The organization has 1–2 formal processes specific to suicide care.
○	3	The organization has written processes specific to suicide care. They have been developed for at least 3 different components of Zero Suicide.
○	4	The organization has processes and protocols specific to suicide care. They address at least 5 components of Zero Suicide. Staff receive training on processes as part of their orientations or when new ones developed. Processes are reviewed and modified at least annually.
○	5	Processes address all components of Zero Suicide listed above. Staff receives annual training on processes and when new ones are introduced. Processes are reviewed and modified annually and as needed.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,208)

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As the Zero Suicide approach relies on the formalization of several policies intended to establish guidelines and promote the adoption of safer suicide care, please consider whether you have established, written policies as well as staff training in the following areas:

	Do you have a written agency protocol specific to this component of suicide care? (yes/no)	Is this component embedded 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 (Character limit: 126)
2. Screening				
3. Assessment				
4. Lethal means restriction				
5. Safety planning				
6. Suicide care management plan				

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7. Create a leadership-driven, safety-oriented culture:

What type of formal commitment has leadership made through staffing to reduce suicide and provide safer suicide care?

» Please select the number where your organization falls on a scale of 1–5.		
○	1	The organization does not have dedicated staff to build and manage suicide care processes.
○	2	The organization has one leadership or supervisory individual who is responsible for developing suicide-related processes and care expectations. Responsibilities are diffuse. Individual does not have the authority to change policies.
○	3	The organization has assembled an implementation team that meets on an as-needed basis to discuss suicide care. The team has authority to identify and recommend changes to suicide care practices.
○	4	The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for developing guidelines and sharing with staff.
○	5	The Zero Suicide implementation team meets regularly and is multidisciplinary. Staff members serve on the team for terms of one to two years. The team modifies processes based on data review and staff input.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit : 1,320)

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8. Create a leadership-driven, safety-oriented culture:

What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities?

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

○	1	Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization.
○	2	Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports.
○	3	Suicide attempt or loss survivors are specifically and formally included in the organization's general approach to suicide care, but involvement is limited to one specific activity, such as leading a support group or staffing a crisis hotline. Survivors informally provide input into the organization's suicide care policies.
○	4	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.
○	5	Suicide attempt and loss survivors participate in a variety of suicide prevention activities within the organization, such as sitting on decision-making teams or boards, participating in policy decisions, assisting with employee hiring and training, and participating in evaluation and quality improvement.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,320)

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9. 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 select 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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,425)

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10. 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 select 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)
- ☐ Connect Suicide Prevention/Intervention Training
- ☐ QPR for Nurses
- ☐ QPR for Physicians, Physician Assistants, Nurse Practitioners and Others
- ☐ safeTALK
- ☐ Other (please name): _____

____ 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. (Character limit: 1,054)

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11. Develop a competent, confident, and caring workforce:
What **advanced** training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff?

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

○	**1**	There is no organization-supported training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management, and no requirement for clinical staff to complete training on suicide.
○	**2**	Training is available on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management through the organization, but it is not required of clinical staff.
○	**3**	Training is required of select staff (e.g., psychiatrists) and is available throughout the organization.
○	**4**	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice and was not internally developed.
○	**5**	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical 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 clinical staff on advanced suicide prevention skills:

- ☐ AMSR (Assessing and Managing Suicide Risk)
- ☐ CASE Approach (Chronological Assessment of Suicide Events)
- ☐ Commitment to Living
- ☐ QPRT Suicide Risk Assessment and Management Training
- ☐ RRSR (Recognizing and Responding to Suicide Risk)
- ☐ RRSR-Primary Care
- ☐ suicide to Hope
- ☐ Other (please name): _____

If you wish to describe or elaborate on any item, please do so in the space provided below. (Character limit: 820)

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12. Systematically identify and assess suicide risk:

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

» Please select 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).

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,444)

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13. Systematically identify and assess suicide risk:

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

» Please select 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-3 ☐ Columbia Suicide Severity Rating-Scale (C-SSRS)

☐ National Suicide Prevention Lifeline Risk Assessment Standards ☐ Other tool (please name): _____

If you wish to describe or elaborate on any item, please do so in the space provided below. (Character limit: 1,416)

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14. Systematically identify and assess suicide risk:

How does the organization **assess** suicide risk among those who screened positive?

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

○	**1**	The policy is to send clients who have screened positive for suicide to the emergency department for clearance AND/OR there is no routine procedure for risk assessments that follow the use of a suicide screen.
○	**2**	Risk assessment is required after screening, but the process or tool used is up to the judgment of individual clinicians AND/OR only psychiatrists can do risk assessments.
○	**3**	Providers conducting risk assessments use a standardized risk assessment tool, which may have been developed in-house. All patients who screen positive for suicide have a risk assessment. Suicide risk assessments are documented in the medical records.
○	**4**	All individuals with risk identified, either at intake screening or at any other point during care, are assessed by clinicians who use validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors.
○	**5**	A suicide risk assessment is completed using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. Staff receive training on risk assessment tool and approach. Risk is reassessed and integrated into treatment sessions for every visit for individuals with risk.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,440)

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15. Ensure every person has a suicide care management plan (pathway to care):
Which best describes the organization's approach to caring for and tracking people at risk for suicide?

A suicide care management plan should include the following:

- Screening
- Assessment and risk formulation
- Safety planning
- Lethal means restriction
- Evidence-based treatment
- Supportive contacts with patients who don't show for appointments and during care transitions

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

○	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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 702)

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16. Collaborative safety planning:

What is the organization's approach to collaborative safety planning when an individual is at risk for suicide?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	Safety planning is neither systematically used by nor expected of staff.
○	**2**	Safety plans are expected for all individuals with elevated risk, but there is no formal guidance or policy around content. There is no standardized safety plan or documentation template. Plan quality varies across providers.
○	**3**	Safety plans are developed for all individuals at elevated risk. Safety plans rely on formal supports or contact (e.g., call provider, call helpline). Safety plans do not incorporate individualization, such as an individual's strengths and natural supports. Plan quality varies across providers.
○	**4**	Safety plans are developed for all individuals at elevated risk and must include risks and triggers and concrete coping strategies. The safety plan is shared with the individual's partner or family members (with consent). All staff use the same safety plan template and receive training in how to create a collaborative safety plan.
○	**5**	A safety plan is developed on the same day as the patient is assessed positive for suicide risk. The safety plan is shared with the individual's partner or family members (with consent).The safety plan identifies risks and triggers and provides concrete coping strategies, prioritized from most natural to most formal or restrictive. Other clinicians involved in care or transitions are aware of the safety plan. Safety plans are reviewed and modified as needed at every visit with a person at risk.

Please indicate whether or not the organization uses the Stanley/Brown safety plan template: ☐ YES ☐ NO
If no, identify the safety planning tool or approach the organization uses:

_____

How frequently is the safety plan reviewed with the individual? _____

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 851)

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17. Collaborative restriction of access to lethal means:

What is the organization's approach to lethal means reduction?

» Please select 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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,062)

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18. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors:
What is the organization's approach to **treatment** of suicidal thoughts and behaviors?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	Clinicians rely on experience and best judgment in risk management and treatment for all mental health disorders. The organization does not use a formal model of treatment for those at risk for suicide.
○	**2**	The organization may use evidence-based treatments for some psychological disorders, but it does not use evidence-based treatments that specifically target suicide.
○	**3**	Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practices.
○	**4**	Individuals with suicide risk receive empirically-supported treatment specifically for suicide (CAMS, CBT-SP or DBT) in addition to evidence-based treatments for other mental health issues. The organization regularly provides all staff with access to competency-based training in empirically supported treatments targeting suicidal thoughts.
○	**5**	The organization has invested in evidence-based treatments for suicide care (CAMS, CBT-SP or DBT), with designated staff receiving training in these models. The organization has a model for sustaining staff training. The organization offers additional treatment modalities for those chronically or continuously screening at high risk for suicide, such as DBT groups or attempt survivor groups.

Please indicate if clinicians in the organization receive formal training in a specific suicide treatment model:

☐ CAMS (Collaborative Assessment and Management of Suicidality)

☐ CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention)

☐ DBT (Dialectical Behavior Therapy)

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,057)

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19. Provide continuous contact and support:
What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't show for appointments?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	There are no guidelines specific to reaching those at elevated suicide risk who don't show for scheduled appointments.
○	**2**	The organization requires documentation by the clinician of those individuals who have elevated suicide risk and don't show for an appointment, but the parameters and methods are up to individual clinician's judgment.
○	**3**	Follow-up for individuals with suicide risk who don't show for appointments includes active outreach, such as phone calls to the individual or his or her family members, until contact is made and the individual's safety is ascertained.
○	**4**	Follow-up for individuals with suicide risk who don't show for appointments includes active outreach, such as phone calls to the individual or his or her family members, until contact is made and the individual's safety is ascertained. Organizational protocols are in place that address follow-up after no-shows. Training for staff supports improving engagement efforts.
○	**5**	The organization may have an established memorandum of understanding with an outside agency to conduct follow-up calls. Follow-up and supportive contact for individuals on suicide care management plans are systematically tracked in electronic health records. Follow-up for high-risk individuals includes documented contact with the person within eight hours of the missed appointment. The organization has approaches, such as peer supports, peer-run crisis respite, home visits, or drop-in appointments, to address the needs of hard-to-reach patients.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

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20. Provide continuous contact and support:

What is the organization's approach to following up on patients who have recently been discharged from acute care settings (e.g., emergency departments, inpatient psychiatric hospitals)?

» Please select 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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

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21. Apply a data-driven quality improvement approach:

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

» Please select 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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,309)

19

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22. Apply a data-driven quality improvement approach:
What is the organization's approach to measuring suicide deaths?

» Please select 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.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,327)

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23. Apply a data-driven quality improvement approach:

What is the organization's approach to quality improvement activities related to suicide prevention?

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

○	1	The organization has no specific policies related to suicide prevention and care, and it does not focus on suicide care other than care as usual. Care is left to the judgment of the clinical provider.
○	2	Suicide care is discussed as part of employee training and by those in supervision in clinical settings.
○	3	Early discussions about using technology and/or enhanced record keeping to track and chart suicide care are underway. Suicide care management is partially embedded in an EHR or paper record.
○	4	Suicide care is partially embedded in an electronic health record (EHR) or paper record. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to organizational policies, and discussed by a team responsible for this.
○	5	Suicide care is entirely embedded in EHR. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows or paper records are updated regularly as the team reviews data and makes changes.

If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,202)

Once your implementation team has completed this organizational self-study using this document, the results can be entered online at http://zerosuicide.sprc.org/what-organizational-self-study.
Should you have additional questions, please email zerosuicide@edc.org

B. Digital Tools to Consider

Summary

App	MY3	CALM HARM	VIRTUAL HOPE BOX
Developer	California Mental Health Services Authority and the Link2Health Solutions	Dr. Nihara Krause, Consultant Clinical Psychologist and stem4 mental health charity for teens	VA Portland Health Care System partnered with the Department of Defense's Telehealth and Technology Center
Description	• Mobile safety planning app • Users define their support network and their plan to stay safe • Add 3 contacts (a network of 3 loved ones) + comes preloaded with National Suicide Prevention Lifeline and 911 • Link to organizations such as suicide attempt survivors, LGBTQ youth, Veterans • Follows Stanley Brown Safety Plan • Can be emailed	• Developed for teenage mental health using the basic principles of Dialectical Behavioral Therapy • Helps users learn to identify and manage their 'emotional mind', teaching impulse control, emotional regulation and tracking underlying triggers to harmful urges. • Provides tasks to hep resist/manage urge to self-harm • Can track progress and notice change	• Smartphone support app • Patient sets up the app with photos of friends and family, sound bites and videos of loved ones and special moments, music, relaxation exercises, games, helpline numbers, and reminders of reasons for living. • The app supports a mix of pre-loaded and user-created content and can be customized according to the patient's specific needs. • App is designed to help with emotional regulation and coping with distress, as well as reasons for living.
Target Population	Everyone	Teenage, 13 years and above	Veterans, but anyone can use it
Research/ Outcomes	None	Pilot study in 8 young patients who self-harmed, later expanded to 14 young people aged between 15-17. Statistically significant results on depression were noted post use. Free answers indicated 84% reduction in self-harm in between appointments. Acceptability was high at 99% and safety was also high 99%. The most popular category was comfort and the most common reason for self-harm was 'I was sad'. App analytics data (to December 2020): There have been over 1.75 million downloads of the Calm Harm app to date. 92% of the individuals who used the Calm Harm app reported that an activity helped to reduce the urge to self-harm.	In a randomized clinical trial, Veterans who used the VHB reported significantly greater ability to cope with unpleasant emotions and thoughts compared with a control group and found the app to be more helpful than written educational materials.
Links	App: LINK	App: LINK / Listed on NHS.uk website Video: https://www.youtube.com/watch?v=JDgdXiEoB2Q	App: LINK

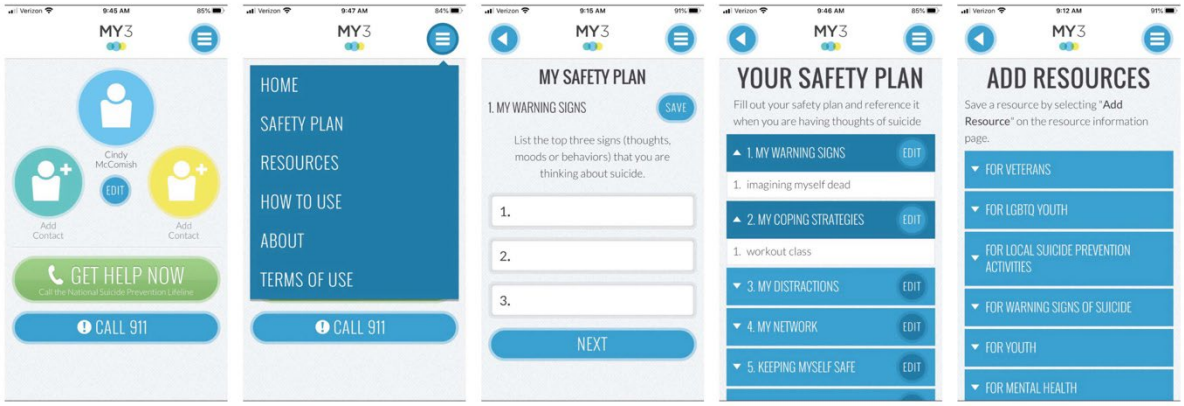
MY3

App	MY3
Description	Suicide prevention app focused on keeping contacts, a personal safety plan, and resources accessible in a crisis.
Components	• Homepage: Choose 3 contacts for easy dialing (add in from address book), buttons for the National Suicide Prevention Lifeline and 911 • Safety Plan: Fill in Stanley Brown Safety Plan, can email to a contact • Resources: pull in personalized options (general, veterans, LGBTQ, etc.)
Notes	• Connects directly to phone address book, easy to enter safety plan by going through each phase and hitting next • Personalized resources allow user to choose what applies to them • Info stored on local device; no account needed
Host/Founder	Mental Health Association of New York City, admin of NSPL

MY3

Experience Screenshots

Users can enter 3 key contacts, fill out a Stanley Brown Safety Plan, add personalized Resources into their Plans, and share the Plan via email.



Home Screen | Menu | Plan Entry | Plan Overiew | Resources

MY3

Emailed Plan Screenshots

1. My Warning Signs
   - Imagining myself dead
2. My Coping Strategies
   - Workout class
3. My Distractions
   - Go to library
4. My Network
   - Cindy McComish : 2069093
5. Keeping Myself Safe
   - Lock meds cabinet
6. My Reason to Live
   - My family

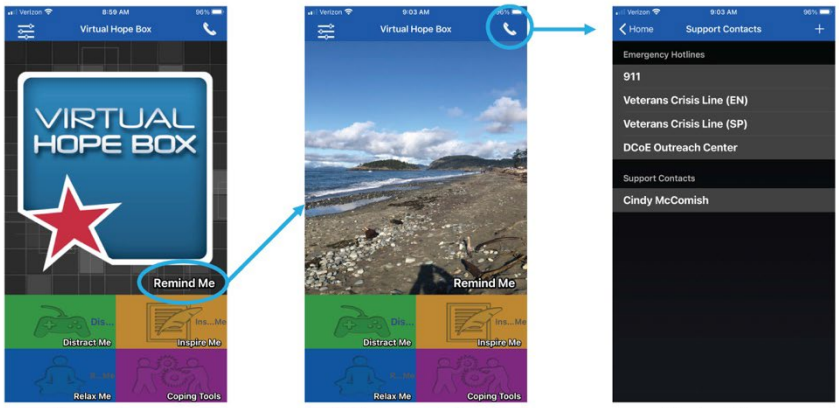
Virtual Hope Box

App	Virtual Hope Box
Description	Mental health app focused on providing simple tools to help patients with emotional regulation (e.g., coping, relaxation, distraction, and positive thinking) and having reasons for living to help manage suicidal ideation.
Components	• Home page: Choose images or sound clips that hold significance to you. Links to 4 buckets of tools (Distract Me, Inspire Me, Relax Me, Coping Tools). Access contacts (user chosen and 911, Veterans Crisis Line in English and Spanish, DCoE Outreach Center) • Each bucket of tools offers selections for different activities
Notes	• Contact resources tailored to veterans • Some comments that required pin is hard to manage when in crisis
Host/Founder	Defense Health Agency (designed for active-duty military and veterans)

Virtual Hope Box

Experience Screenshots

Users can load in images to remind them of positive memories, find activities in different categories, or find contacts for help.

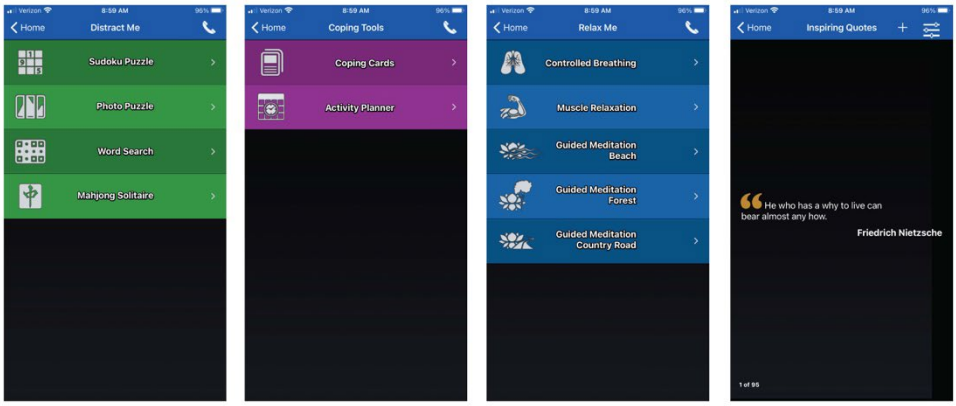


Home Screen | With Image Added | Contact Page

Virtual Hope Box

Experience Screenshots

Each Section provides different options for coping skills, activities, or quotes related to the category the user chose.



Distract Me | Coping Tools | Relax Me | Inspire Me

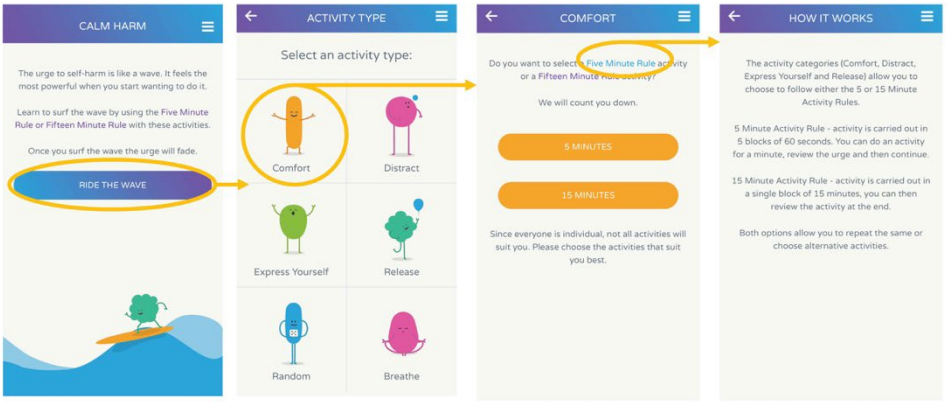
Calm Harm

App	Calm Harm
Description	Calm Harm provides tasks to help you resist or manage the urge to self-harm.
Components	• Activities in 5 categories (comfort, distract, express yourself, release, and breathe) with options for one minute and 15-minute activities. • Journal captures data after each activity (or set of activities) • Resources help
Notes	• App created in UK but resources adjust for US-based users • Developed for teen audience, but seems relevant to broad audience • Internal advertisement included for another app product they've created (Combined Minds is an app to provide information for families or others to support a young person with mental health struggles)
Host/Founder	Stem4 (teen mental health charity based in UK)

Calm Harm

Experience Screenshots

Initial experience guides users to activities and allows to choose time-based offerings.

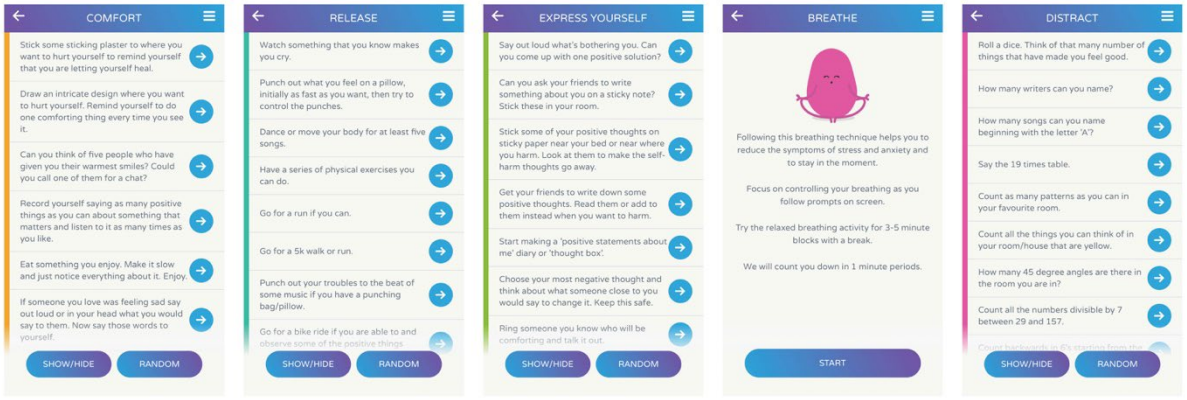


Welcome Screen | Activity Menu | Time Choice | Timing Descriptions

Calm Harm

Experience Screenshots

Each Section has options for short (5x1 min) and longer (15 min) activities.

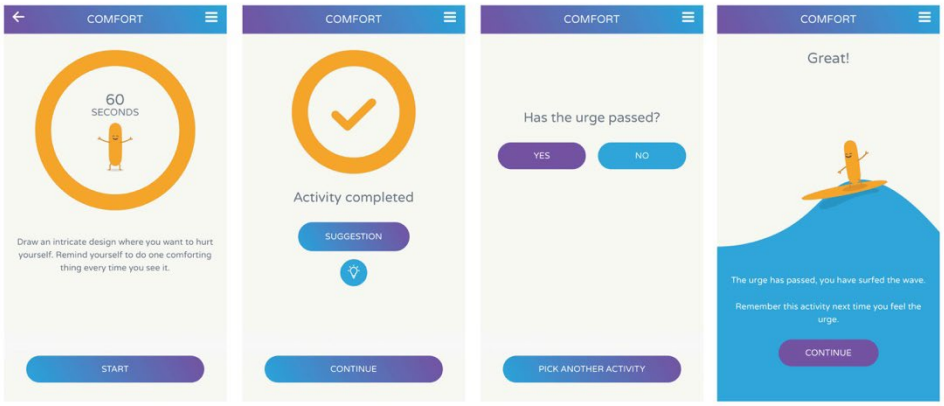


Comfort | Release | Express Yourself | Breathe | Distract

Calm Harm

Experience Screenshots

Activity completion process.

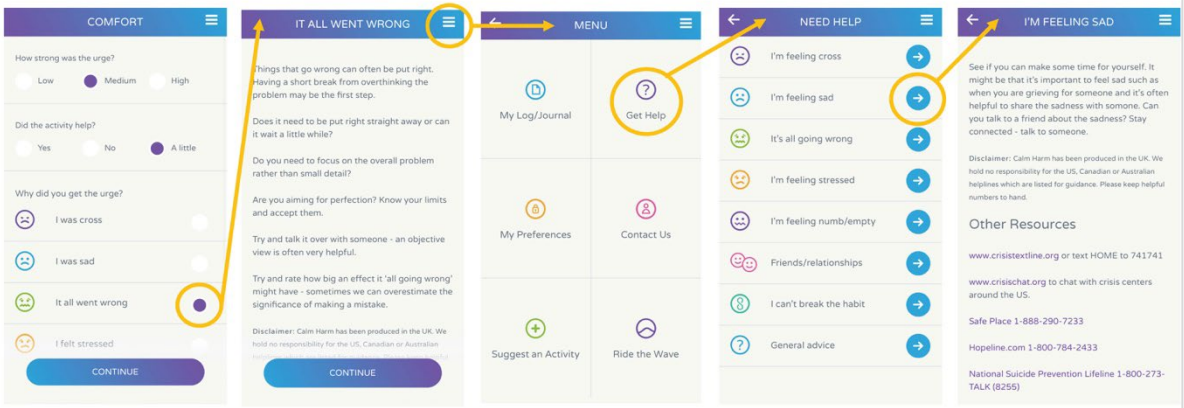


Activity with Timer | Completion | Check-in (If No – Repeat 60 second activity) | Recognition

Calm Harm

Experience Screenshots

Following coping skill completion, a link is provided for an additional mental health app, then a journal entry.

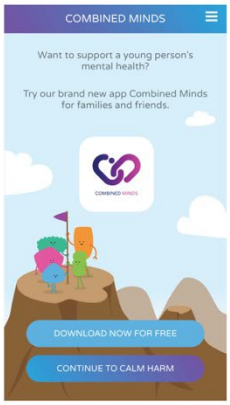


Journal | Education | Accessing Journal | Get Help Menu | Feeling Sad Resources

Calm Harm

Experience Screenshots

Note that the app includes a single screen advertisement promoting another app by this organization. Combined Minds is a tool to help families and others support adolescents with mental health challenges.



Combined Minds Link

C. Recommendations for Implementing Zero Suicide in Primary Care clinics without integrated Behavioral Health

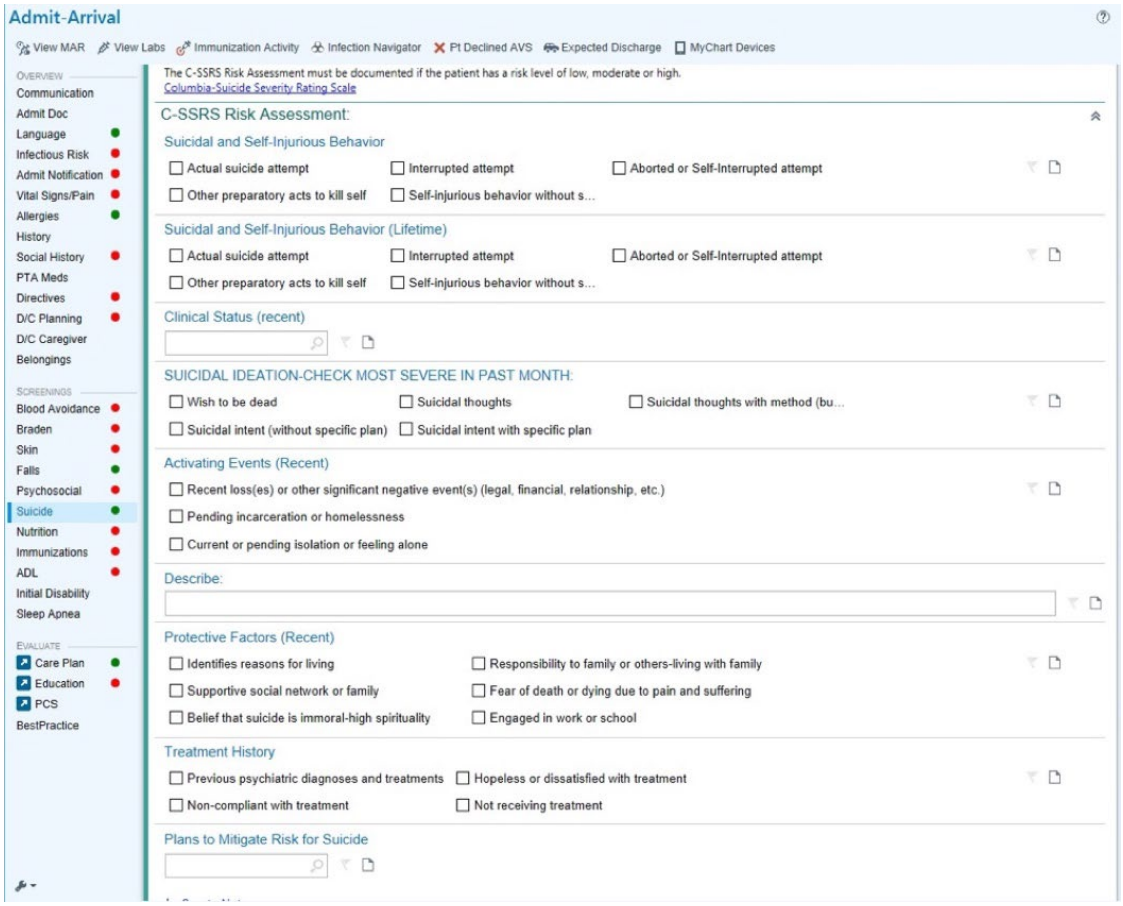
It is understood that implementing a new pathway in the primary care setting can prove burdensome for an already fast-paced clinical environment. However, it is also known that patients experiencing suicidal ideation currently present in primary care clinics and are met with varying levels of care. Offering evidence-based tools for early identification, effective response and treatment will ease the way of primary care providers and teams. While the availability of embedded behavioral health clinicians is optimal for delivering this pathway with high reliability and confidence, there is evidence of efficacious implementation in Providence clinics without such resources. Below are some suggestions intended to support clinics without integrated BH available.

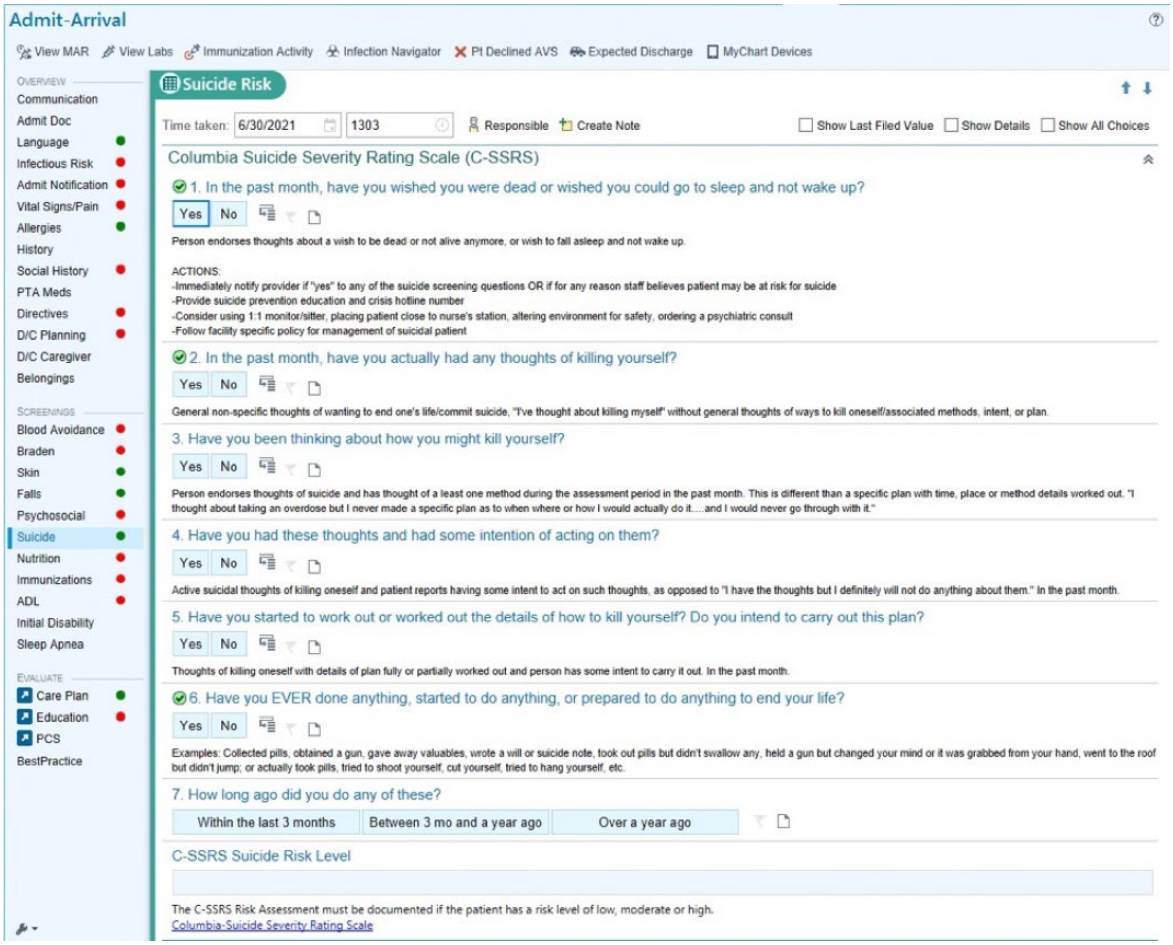
Key Actions & Recommendations

- Depression Screening (PHQ-9)
    - In-person visit: Issued by Medical Assistant or at check-in
    - Virtual visit: Issued via MyChart
- CSSRS Screening & Risk Assessment
    - Soft prompt triggered to give CSSRS when positive item 9 endorsed on PHQ
    - CSSRS offers risk level stratification
- Safety Planning
    - Min Spec: no embedded BH provider/care manager
        - MA/clinical care team switches appointment agenda
        - Primary Care provider conducts safety plan intervention as main issue
        - Make arrangements to address original appointment issue(s)
        - Share resources for follow up
    - Best practice:
        - Follow up appointment with BH provider in clinic or community
        - BH provider performs safety planning intervention with patient
        - Referral to resources
    - Safety plan should be provided to patient in After Visit Summary
    - If patient is in acute crisis, referral to Emergency Department or County Crisis Services (where available)
- Training Recommendations
    - CSSRS training at provider "pod" meetings and/or for providers as part of CME
    - Safety Plan training at "pod" meetings and/or for providers as part of CME – clarify as simple but valuable; in most cases, PCP has greatest trust relationship with patient

D. Providence Epic Screening & Safety Planning

Screening & Assessment





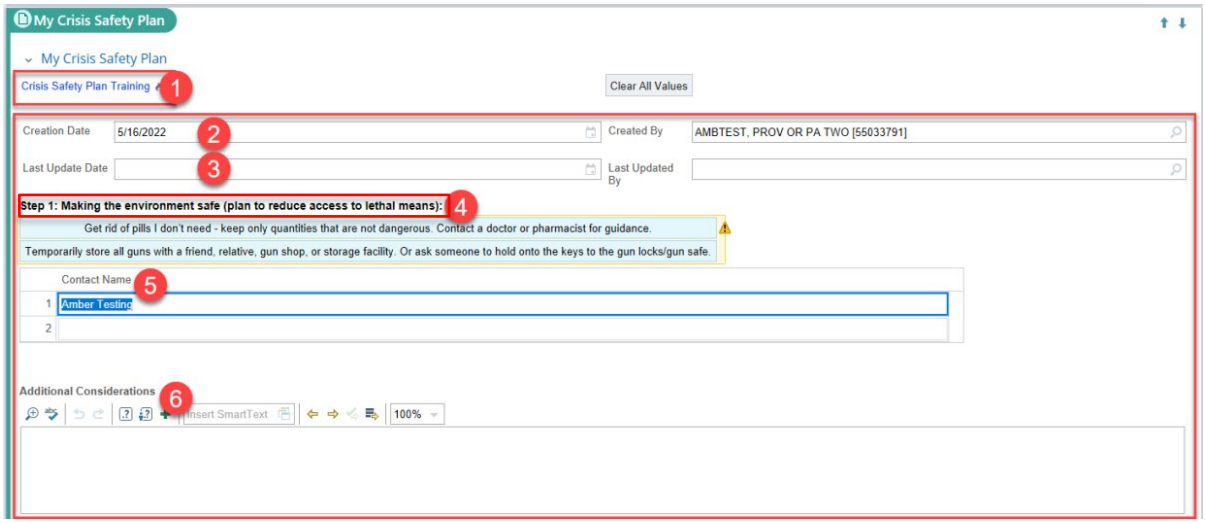
Crisis Safety Plan

As a part of the National Patient Safety Goal for Suicide Prevention (NPSG 15.01.0), it is required for all accredited hospitals to meet Elements of Performance (EP) to decrease the risk of suicide in our country. DNV has similar requirements. One of the requirements, EP6, requires a suicide safety plan be developed with patients prior to discharge.

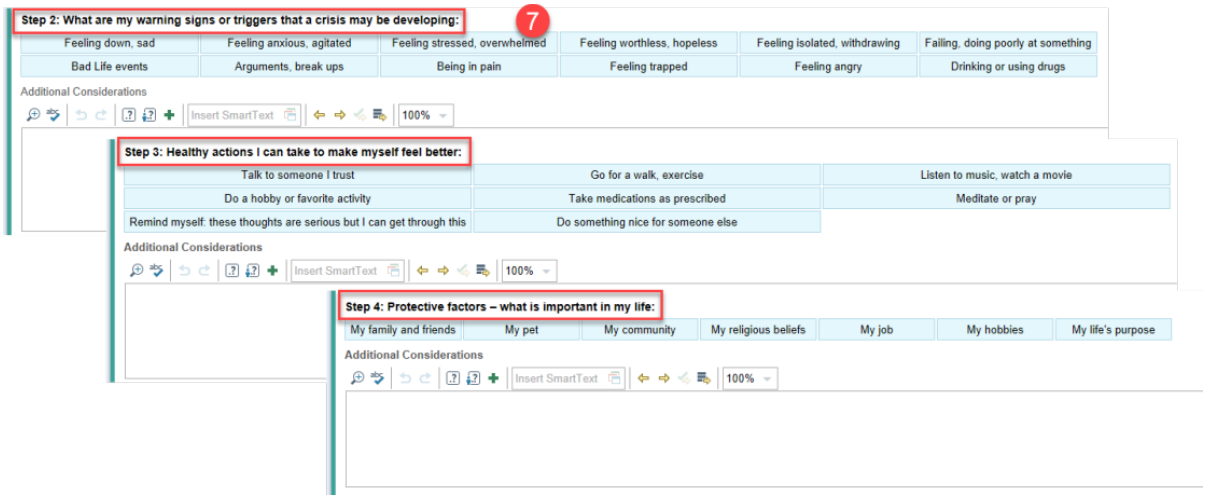
The Crisis Safety Plan is a SmartForm that aids in developing a specific safety plan for a patient and can be updated as needed.
IMPORTANT: All six steps in the Safety Plan steps must be completed before a Safety Plan will be considered complete. If all six steps are not completed, the Safety plan will not be visible to caregivers in other care settings (ED, Inpatient, etc.).

1. The use of Safety Planning, an evidence-based intervention, is recommended by the Joint Commission as a standard of care for those who have been identified as being at risk for suicide. Click the **Crisis Safety Plan Training** link to review Safety Planning information.
2. For initial creation of a Crisis Safety Plan for a patient, enter a **Creation Date** and **Created By**.
3. For updates to an existing Crisis Safety Plan, enter **Last Update Date** and **Last Updated By**.

4. **Step 1: Making the environment safe (plan to reduce access to lethal means)** is a required field. Select from the options listed.
5. Enter a **Contact Name** when addressing step one.
6. Enter comments (if needed) in the **Additional Considerations** field.

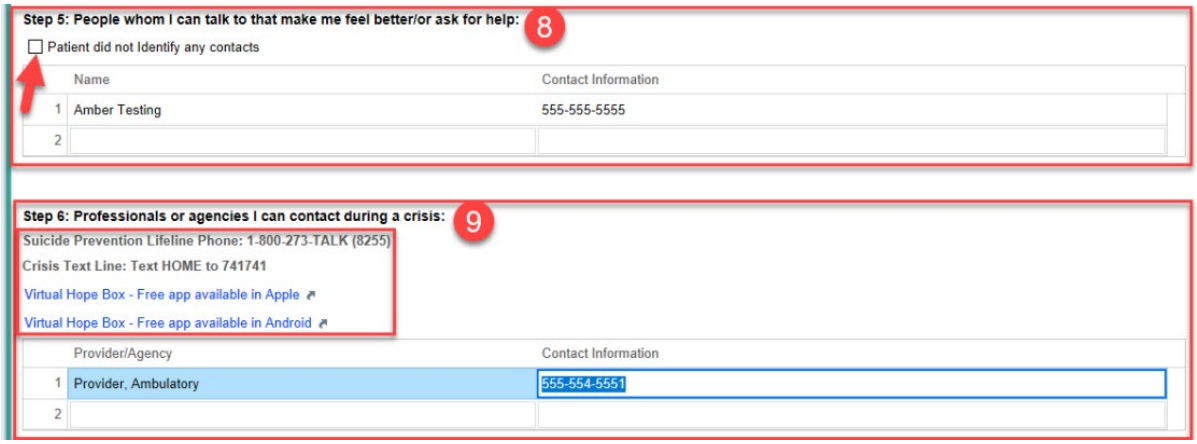


7. Add pertinent information for **Step 2, Step 3**, and **Step 4**.
    - Enter comments (if needed) in the **Additional Considerations** fields below Steps 2, 3 and 4



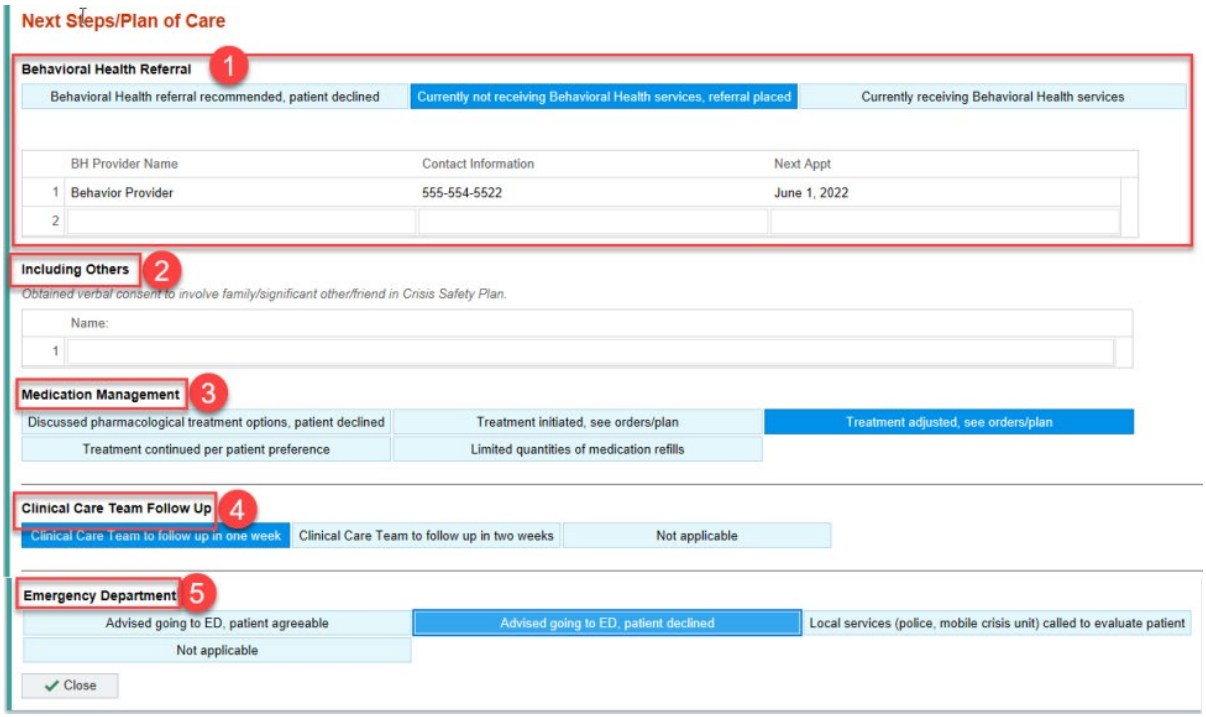
8. Add contact information for **Step 5: People whom I can talk to that make me feel better/or ask for help**.
    - Click the **Patient did not Identify any contact**s checkbox if applicable to the patient.
9. Add pertinent information to **Step 6: Professionals or agencies I can contact during a crisis**.
    - The Suicide Prevention Lifeline Phone # and Crisis Text Line information displays.
    - There are links to Virtual Hope Box - a smartphone application for use by patients and their behavioral health providers as an accessory to treatment. It is available for both Apple and

Android and the links will also be available to patients that access the Crisis Safety Plan in MyChart.



Next Steps/Plan of Care
Add relevant information regarding next steps and the plan of care for the patient.

1. **Behavioral Health Referral**: Select an option.
2. **Including Others**: If verbal consent has been obtained to involve family/significant other/friend in Crisis Care Plan, add the name(s) of the individual(s).
3. **Medication Management**: Select pertinent option(s) regarding medication management.
4. **Clinical Care Team Follow Up**: Select an option (if applicable).
5. **Emergency Department**: Select an option (if applicable).



E. Crisis Safety Plan SmartForm

Suicide is a public health crisis. The use of Safety Planning, an evidence-based intervention, is recommended by the Joint Commission as a standard of care for those who have been identified as being at risk for suicide.

What is Safety Planning?

Safety Planning is an intervention in which a Safety Plan is developed collaboratively between the patient and clinician. It involves identifying warning signs or triggers for a suicidal crisis, constructing a list of healthy activities/strategies to help the patient manage the suicidal crisis, listing their reasons for living and supportive social contacts, providing crisis resources, and taking steps to ensure that their environment is safe (means safety).

Step 1: Means Safety

In this step we are assessing for lethal means and engaging in Safety Planning all at once. Lethal means are method for suicide that have a higher potential for harm when compared to other methods. Pills and firearms are examples of lethal means. The goal of means safety is to increase the time and distance between the patient and their access to the lethal means during a suicidal crisis.

- ☐ Get rid of pills I don't need – keep only quantities that are not dangerous. Contact a doctor or pharmacist for guidance.
- ☐ Temporarily store all guns with a friend, relative, gun shop or storage facility. Or ask someone to hold onto the keys to the gun locks/gun safe.
- ☐ Contact Name (s): _____
- ☐ Additional considerations: _____

Step 2: Identify Triggers or Warning Signs

Identifying warning signs or triggers can help the patient better cope because when they are aware of these triggers, they can take action to manage them. Warning signs can range from emotions, thoughts to arguments or events.

- ☐ Feeling down, sad
- ☐ Felling isolated, withdrawing
- ☐ Being in pain
- ☐ Feeling anxious, agitated
- ☐ Failing, doing poorly at something
- ☐ Feeling trapped
- ☐ Feeling stressed, overwhelmed
- ☐ Bad life events
- ☐ Feeling angry
- ☐ Feeling worthless, hopeless
- ☐ Arguments, breakups
- ☐ Drinking or using drugs
- ☐ Additional considerations: _____

Step 3: Patient led healthy actions to help the patient manage their crisis

This includes positive enjoyable activities, reaching out to others, and relaxing/soothing activities.

- ☐ Talk to someone I trust
- ☐ Listen to music, watch a movie
- ☐ Take my medication as prescribed
- ☐ Remind myself: these thoughts are serious, but I can get through this
- ☐ Go for a walk, exercise
- ☐ Do a hobby or favorite activity
- ☐ Meditate or pray
- ☐ Do something nice for someone else
- ☐ Additional considerations: _____

Step 4: Reasons for living

When patients are in a suicidal crisis, they may not immediately connect with what is most important in their life, listing this on their Safety Plan helps connect the patient to what is truly important to them whether that is their family, pets, personal growth and/or their religious beliefs.

- ☐ My family and friends
- ☐ My pet
- ☐ My community
- ☐ My religious beliefs
- ☐ My job
- ☐ My hobbies
- ☐ My life's purpose
- ☐ Additional considerations: _____

Step 5: Social supports

It can be helpful for the patient to have a list of individual(s) they can talk with when they are experiencing a suicidal crisis. This may be someone whom they can trust and/or someone who can distract them, or someone who makes them feel better.

- ☐ Patient did not identify any contacts
- ☐ Contact Names & Contact Information: _____

Step 6: Crisis Resources

Patients are given resources that they can call (National Suicide Prevention Lifeline), text (Crisis text line) or an app they can use (Virtual Hope Box)

Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
Crisis Text Line: Text HOME to 741741
Virtual Hope Box – Free app available in Apple
Virtual Hope Box – Free app available in Android

If I am feeling suicidal, I can also dial 911 or go to the nearest emergency room.

- ☐ Provider/Agency & Contact Information: _____

Next Steps / Plan of Care

Next Steps/Plan of Care: Joint Commission recommends having a plan of care for in place when working with patient who at risk for suicide.

Behavioral Health treatment: We assess if the patient is currently receiving BH treatment. If they are, it allows the clinical care team to obtain consent to reach out to the BHP and let them know that the patient is at risk for suicide and a safety plan has been developed. If the patient is not engaged in BH treatment, a referral can be placed. The clinical care team can also document if the patient declines the BH referral.

- ☐ Behavioral Health referral recommended; patient declined
- ☐ Currently receiving Behavioral Health Services
- ☐ Currently not receiving Behavioral Health Services; referral placed.
- ☐ BH Provider Name, Contact Information, Next Appt: _____

Including Others: The patient can identify a family member/significant other/friend to include in the Safety Plan. This individual may have already been identified to help manage medications, or for ensuring firearms safety or as a social support. The clinician can encourage the patient to call this individual from their phone on speaker setting during the appointment and include them in the Safety Plan.

- ☐ Contact names of family/significant other/friend: _____

Medication Management: This step allows the clinician to document medication management: initiating medication, adjusting medications, continuing medication. It also offers the option of limiting the quantities of medication available to the patient.

- ☐ Discussed pharmacological treatment options, patient declined
- ☐ Treatment imitated; see orders/plan
- ☐ Treatment adjusted, see orders/plan
- ☐ Treatment continued per patient preference
- ☐ Limited quantities of medication refills

Clinical Care Team Follow Up: A follow up phone contact for patients who have engaged in Safety Planning has been found to decrease the risk for suicide attempt. Depending on the assessed risk of the patient, clinical resources available, and clinical judgment; the plan of care can include a follow up call.

- ☐ Clinical Care Team to follow-up in one week
- ☐ Clinical Care Team to follow-up in two weeks
- ☐ Not applicable

Emergency Department (Imminent Risk): Depending on the assessed level of risk a clinician may recommend that the patient present to the Emergency Department. It allows the clinician to document whether the patient is agreeable to this recommendation, or if they decline. It also allows the clinician to consider, when appropriate, the option of involving local services to evaluate the patient.

- ☐ Advised going to ED; patient agreeable
- ☐ Advised going to ED; patient declined
- ☐ Local services (police, mobile crisis unit) called to evaluate patient
- ☐ Not applicable

F. Example: Charter

[Project Name] Charter

Problem Statement:

*Suggested format: **What** (what is the problem), **Who** (who is involved), **When** (frequency of problem occurrence), **Where** (Location of the Problem), **How/How Much** (how bad is the problem)*

Aim Statement:

Measures you ultimately want to move. All projects must have a SMART (Specific, Measurable, Agreed Upon, Realistic, Time Bound) outcome goal. (i.e. I will arrive to meetings on time 100% of the time within 3 months.)

Outcome Measurement:

Measures you ultimately want to move. They tell you how the system is performing, i.e., what is the ultimate result? (i.e. percent of the time you arrive punctually to meetings)

Balancing Measures:

Measures to track that you do not unintentionally decrease a different component of the quadruple aim (outcomes, cost, patient experience and caregiver satisfaction)

Project Scope:

Words -what is included and excluded

Project Sponsor:

Name

Process Owners:

Name(s)

Forecasted Financial Benefit:

$000,000

Project Scope:

Names

Strategic Alignment:

Words

Project Scope:

Names

F. Template: Charter

_____ **Charter**

Project Title

Problem Statement:

Aim Statement:

Outcome Measurement:

Balancing Measures:

Project Scope:

Project Sponsor:

Process Owners:

Forecasted Financial Benefit:

Project Team Members:

Strategic Alignment:

Quad Members:

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Providence Medical Group, SW Washington

Stacia Fisher, MSW, LICSW, ACM
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TRUST