Zero Suicide Implementation in Oregon

Oregon Health Authority, Grants to Implement Zero Suicide in Health Systems

2022 Zero Suicide Implementation Assessment Report:

(1) 2022 Implementation Snapshot for 7 Healthcare Systems

(2) Cross-Site Progress in Implementation for 5 Healthcare Systems at

Baseline (Summer 2018), Midpoint (Summer 2019) & Follow-up (2021/Winter 2022)

Data sources: 2018: Organizational Self-Study. Limited Discussion with staff. 2019 & 2021: PSU Zero Suicide web survey (Modified Organizational Self-Study anchored with Zero Suicide Metrics). Staff discussions.

Element #1: Lead (Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.)

Element #2: Train (Develop a competent, confident and caring workforce.)

Element #3: Identify (Systematically identify and assess suicide risk among people receiving care.)

Element #4: Engage (Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet patient needs.)

Element #5: Treat (Use effective, evidence-based treatments that directly target suicidality.)

Element #6: Transition (Provide continuous contact and support, especially after acute care.)

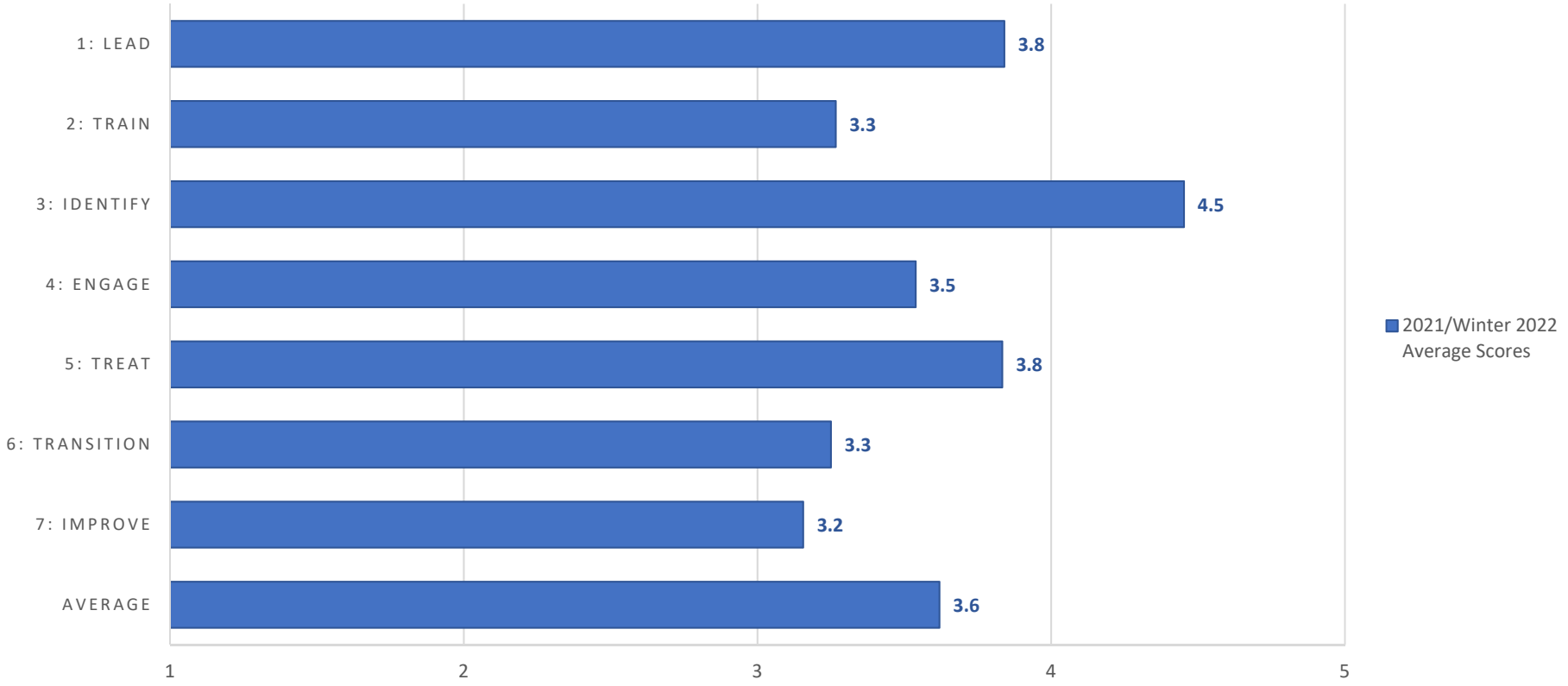
Element #7: Improve (Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.)

 Suggested citation:

Cellarius, K, Tuttle, A. (2022) 2022 Zero Suicide Implementation in Oregon: Cross-Site Follow-up Change Report. Portland, OR: Portland State University.

Zero Suicide Implementation in Oregon:
2022 Implementation Snapshot for 7 Healthcare Systems

(Data sources: Zero Suicide Implementation Assessments conducted Fall/Winter 2021/2022.



Scale: 1=Routine care or care as usual 3=Several steps towards improvement made 5=Comprehensive practices in place

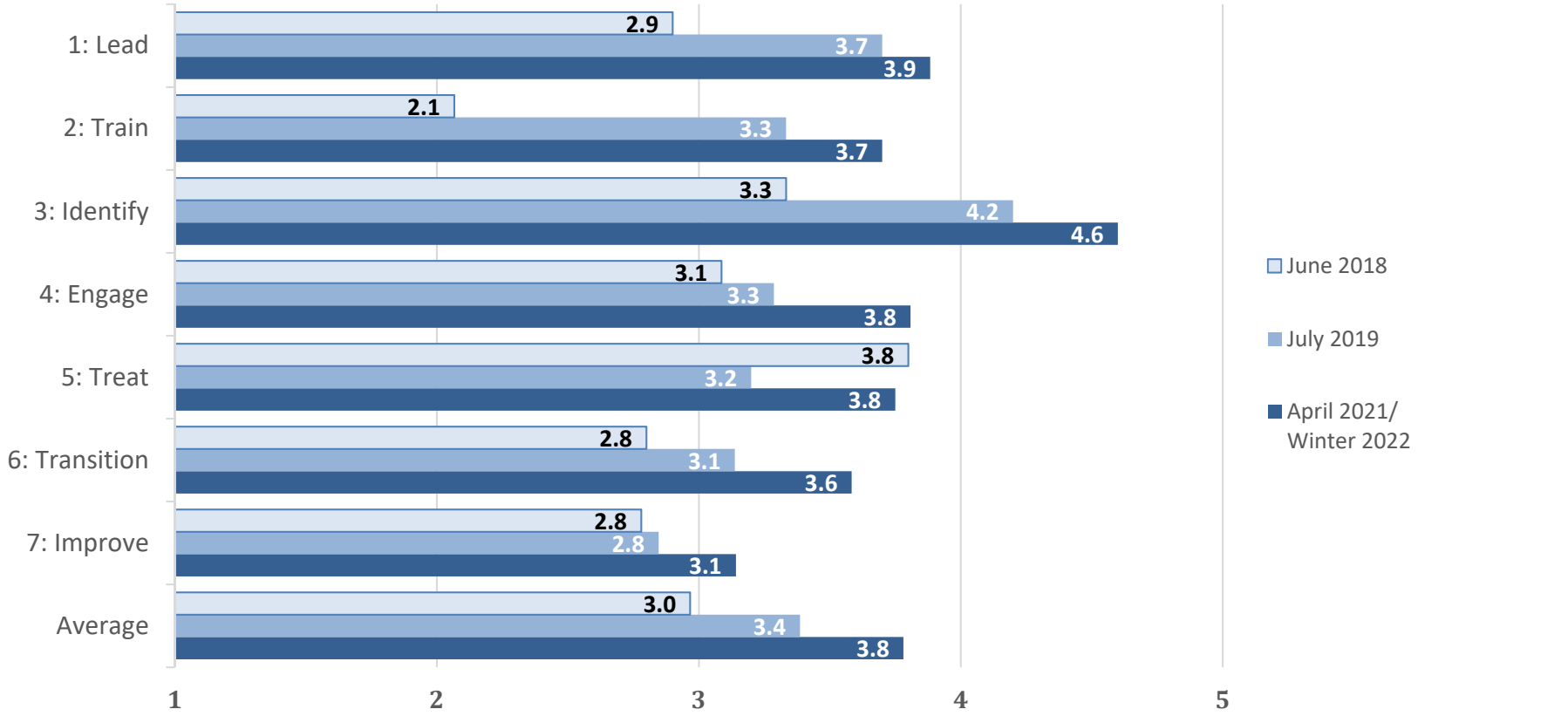
The remainder of this report addresses the change over time for the subset of five health systems that had previously completed the study.

Zero Suicide Implementation in Oregon

Cross-Site Progress in Implementation for 5 Healthcare Systems

Average Implementation Scores at Baseline (2018), Midpoint (2019) & Follow-up (2021/2022)

(Data sources: Organizational Self Study. Zero Suicide Metrics. Conversations with staff)



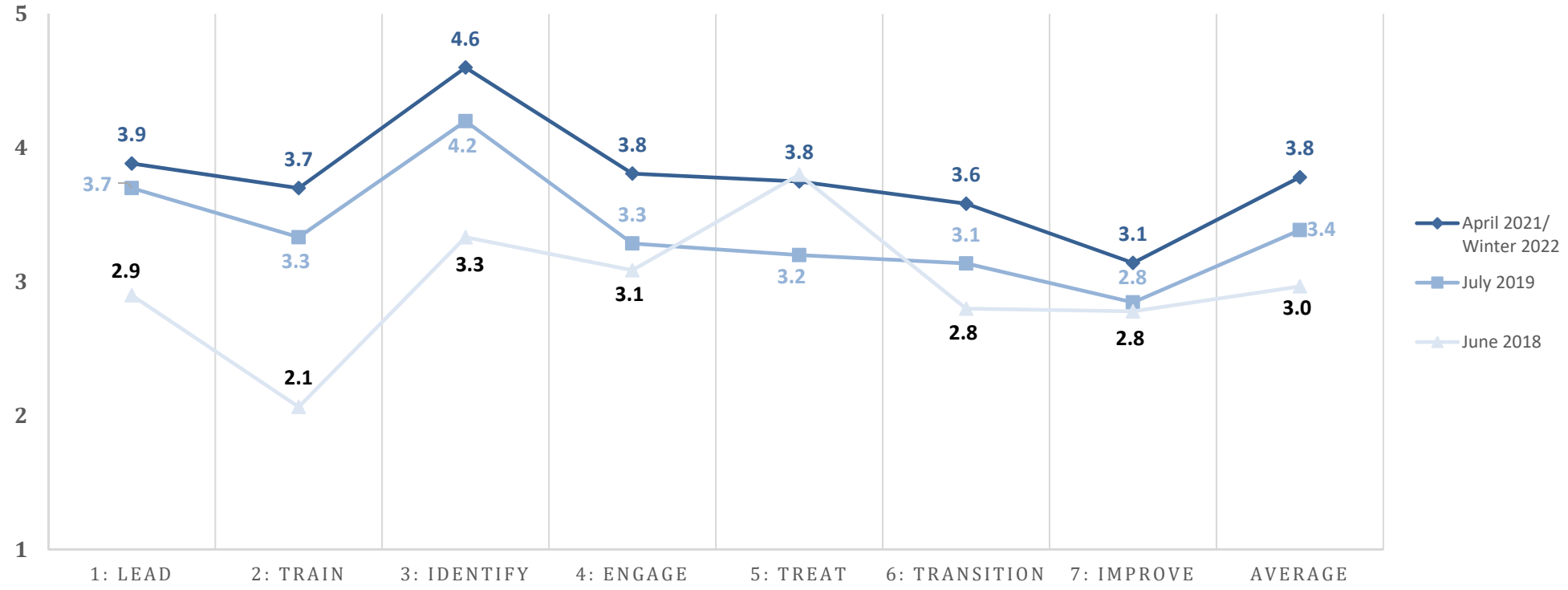
Scale: 1=Routine care or care as usual 3=Several steps towards improvement made 5=Comprehensive practices in place

Note: Change in self-reported score at Midpoint may be due in part to the addition of a related metric from the data elements worksheet rather to a change in practice.

Zero Suicide Implementation in Oregon

Cross-Site Progress in Implementation for 5 Healthcare Systems

Average Implementation Scores at Baseline (2018), Midpoint (2019) & Follow-up (2021/2022)

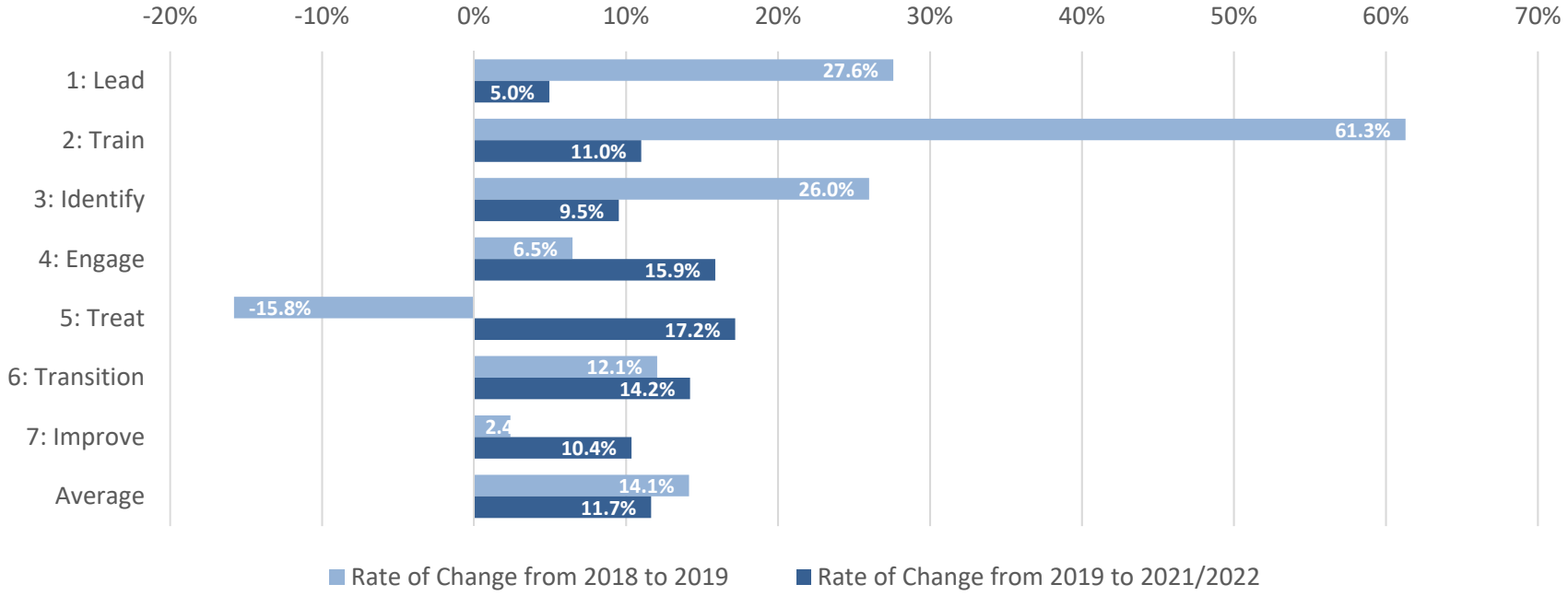


Scale: 1=Routine care or care as usual 3=Several steps towards improvement made 5=Comprehensive practices in place

Zero Suicide Implementation in Oregon

Rate of Change in Average Zero Suicide Implementation for 5 Healthcare Systems

at Baseline (2018), Midpoint (2019) & Follow-up (2021/2022)



Zero Suicide Elements sorted in descending order by rate of change from 2019 to 2021:

Element	2018	2019	Rate of Change from 2018 to 2019	2021	Rate of Change from 2019 to 2021
5: Treat	3.8	3.7	⇩ 15.8 %	3.8	⇧ 17.2 %
4: Engage	3.1	3.3	⇧ 6.5 %	3.8	⇧ 15.9 %
6: Transition	2.8	3.1	⇧ 12.1 %	3.6	⇧ 14.2 %
2: Train	2.1	3.3	⇧ 61.3 %	3.7	⇧ 11.0 %
7: Improve	2.8	2.8	*No Change*	3.1	⇧ 10.4 %
3: Identify	3.3	4.2	⇧ 26.0 %	4.6	⇧ 9.5 %
1: Lead	2.9	3.7	⇧ 27.6 %	3.9	⇧ 5.0 %
Average	**3.0**	**3.4**	**⇧ 14.1%**	**3.8**	**⇧ 11.7%**

Zero Suicide Implementation in 5 Oregon Health Systems 2018-2021
Average Change in Scores by Indicators within each Element

Scale:

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

INDICATOR	2018	2019	2021/ 2022
Element #1: Lead **Mean→**	**2.9**	**3.7**	**3.9**
Comprehensive Processes for Suicide Prevention & Care*	3.4	3.6*	3.8
Staff Awareness of Written Protocols	3.0	4.2	4.3
Documentation of Suicide Care Components	3.2	3.8	4.4
Availability of Trainings	2.8	3.6	3.8
Dedicated Staff Time for Zero Suicide	2.8	4.2	4.0
Survivor Involvement in Planning and Processes	2.2	2.8	3.0
Element #2: Train **Mean→**	**2.1**	**3.3**	**3.7**
Assessment of Workforce Confidence	1.4	2.6	3.0
Trainings for Non-Clinical Staff	2.2	3.4	4.3
Trainings for Clinical Staff	2.6	4.0	3.8
Element #3: Identify **Mean→**	**3.3**	**4.2**	**4.6**
Screening for Suicide Risk**	3.6	3.8**	4.6
Screening Tools Used	3.0	4.4	4.8
Suicide Risk Assessment**	3.4	4.4**	4.4

INDICATOR	2018	2019	2021/ 2022
Element #4: Engage **Mean→**	**3.1**	**3.3**	**3.8**
Care for Patients At Risk for Suicide	2.9	3.3	3.7
Collaborative Safety Planning**	3.4	2.8**	3.8
Collaborative Means Restriction**	3.0	3.8**	4.0
Element #5: Treat **Mean→**	**3.8**	**3.2**	**3.8**
Treatment Approach**	3.8	3.2**	3.8
Element #6: Transition **Mean→**	**2.8**	**3.1**	**3.6**
Engaging Hard to Reach Patients	2.6	2.9	3.7
Follow-up after Discharge	3.0	3.4	3.5
Element #7 Improve **Mean→**	**2.8**	**2.8**	**3.1**
Analysis of Suicide Deaths**	2.9	2.5**	3.2
Tracking Suicide Deaths**	2.6	2.4**	2.8
Continuous Quality Improvement (CQI)**	2.8	3.6**	3.5

**Description in the follow-up survey was changed to clarify that* this indicator measures implementation of *the 5 components of ZS [(1) screening, (2) assessment, (3) lethal means restriction, (4) safety planning, and (5) suicide care management)] and not the 7 elements of ZS (see table above). Because the score might change due to this clarification rather than due to a change in practice, it was not included in the calculation of the overall average for Element 1.*

***Change in self-reported score at follow-up may be due in part to the addition of a related metric from the data elements worksheet rather to a change in practice.*

Element #1: Lead

Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

Comprehensive Processes for Suicide Prevention and Care	Rating	1	2	3	4	5
Has your organization developed and/or implemented any processes around the five components of Zero Suicide: (1) screening, (2) assessment, (3) lethal means restriction, (4) safety planning, and (5) suicide care management? [Original: *What type of commitment has leadership made to reduce suicide and provide safer suicide care? Question was revised from ZS org assessment, but responses remain the same*.]	**3.8**	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.	The organization has 1–2 formal processes specific to suicide care.	The organization has written processes specific to suicide care. They have been developed for at least 3 different components of Zero Suicide.	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.	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.
	Comment or justification for score: **Slight increase from an average of 3.6 to 3.8.** Aggregated Comments from Sites in 2021/Winter 2022: The site with the highest score reports using PreManage with regional emergency departments to notify clinical staff of ED visits by individuals in care. Current guidelines indicate that individual must be seen within 7 days of discharge from hospital. This site conducts risk assessments at all clinical intakes, along with crisis and safety planning. They use CAMS, CALM, QPR, and DBT for assessments & interventions. Another site reports a detailed policy and procedure in place that are very specific to suicide care supporting all five components. At this site, all clinic staff are trained according to roll during the onboarding process with follow up as needed. In process: One site is developing an anniversary tickler system for past suicidal gestures/attempts and systems to track individuals who have demonstrated tendencies or history of suicidal ideations, identify risk factors, and offer support strategies to address, including prevention and intervention. A third site expressed the need to work on follow-up for no-shows in outpatient programs for clients with history of suicidal ideation. They would like more information about clients following discharge from care. An additional site is creating a presentation about how the ZS Framework supports other organizational safety goals. *One site did not comment on this metric.*					

Staff Awareness of Written Protocols	Rating	1	2	3	4	5
Does organization have written protocols for specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means restriction, (4) safety planning, and (5) suicide care management plans?	**4.3**	The organization has not discussed any protocols related to suicide care in the past year. No written policies exist.	The organization has discussed protocols related to suicide care in the past year, and is in the process of developing written policies.	The organization has adopted written policies for at least 2 of the 5 named components of suicide care.	The organization has adopted written policies for at least 4 of the 5 named components of suicide care, but they have not been discussed with staff.	The organization has written policies for all five of the named policies, and leadership has reviewed them verbally with staff.
Comment or justification for score: **Average score increased from 4.2 to 4.3.** Aggregated Comments from Sites in 2021/Winter 2022: One site will begin implementing a new electronic health record (EHR) system in October 2021, which will eventually incorporate consistent screening, assessment, planning, and care pathway tools across all MCHHS programs. This site has a training matrix built for all job classifications, and specific policies/trainings to support implementation of protocols are in the works. A second site reported recently revising and retraining to their policy and procedure on suicide care, and recently implemented a risk analysis process which assists in identifying gaps. *Three sites did not include comments on this metric.*						

Documentation of Suicide Care Components	Rating	1	2	3	4	5
Are specific components of suicide care embedded in organization's electronic health record or easily identifiable in your written documentation (if no EHR is available), including (1) screening, (2) assessment, (3) lethal means restriction, (4) safety planning, and (5) suicide care management plans?	**4.4**	No suicide care components are embedded in organization's electronic health record or written documentation.	The organization has discussed embedding suicide care components into the EHR, but they are not currently active data fields.	At least 2 of the 5 named components of suicide care are embedded into the EHR or written documentation.	At least 4 of the 5 named components of suicide care are embedded into the EHR or written documentation, but they are required or routinely documented by staff.	All of the 5 named components of suicide care are embedded into the EHR or written documentation, and they are required or routinely documented by staff.
Comment or justification for score: **Average score increased from 3.8 to 4.4** Aggregated Comments from Sites in 2021/Winter 2022: One site has recently hired a Zero Suicide Program Coordinator to help streamline implementation of ZS processes into programs. This site uses pathway to care workflows for each program which are being developed with the EHR team. This site also recently developed Suicide Attempt Review Committee to provide intentional suicide care to individuals in service who have frequent suicide attempts. A second site uses their EMR, Epic, to capture the five named components as well as scan in additional safety plans and other documentation by outside partners. A third site reports that safety planning was added to their EHR in 2019. *Two sites did not include comments on this metric.*						

Availability of Trainings	Rating	1	2	3	4	5
Is training provided on specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means restriction, (4) safety planning, and (5) suicide care management plans?	**3.8**	No training has been developed or provided on specific components of suicide care.	The organization is developing or choosing an existing training curriculum on suicide care, and is in the process of scheduling training dates.	The organization has conducted at least one training on at least 2 of the 5 named components of suicide care.	The organization has conducted at least one training on at least 4 of the 5 named components of suicide care, and at least 50% of administrative and direct service staff have been trained.	The organization has conducted multiple trainings on all five of the named suicide care components, and 100% of current administrative and direct service staff have been trained.

Comment or justification for score: **Average score increased from 3.6 to 3.8.**
Aggregated Comments from Sites in 2021/Winter 2022: The site that recently hired a ZS Coordinator will provide additional staff trainings using new training software, Absorb, which will also help track completed trainings. This site reports approximately 95% of administrative staff are aware of their training matrix requirements and approximately 80% of direct care staff are meeting training matrix requirements. Their training matrix also includes trainings that meet QMHA/QMHP certification requirements. Another site commented, "A year or so ago I would have said that yes, 'all staff within our pediatric program'. However, we have had turnover throughout the pandemic and have not fully trained all staff to the extent that others were trained, i.e.; ASSIST, trauma informed care, etc." A third site reports all staff with an access badge are trained in suicide safety but their training might not include all 5 components. *Two sites did not include comments on this metric.*

Dedicated staff time for Zero Suicide	Rating	1	2	3	4	5
What type of formal commitment has leadership made through staffing to reduce suicide and provide safer suicide care?	**4.0**	The organization does not have dedicated staff to build and manage suicide care processes.	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.	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.	The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for developing guidelines and sharing with staff.	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.

Comment or justification for score: **Average score decreased slightly from 4.2 to 4.0.**
Aggregated Comments from Sites in 2021/Winter 2022: One site recently hired a ZS Coordinator to continue supporting implementation of the ZS initiative, facilitate regular meetings, and shepherd the pathways to care into EHR initiative. This site recently developed a Suicide Attempt Review Committee, featuring a multidisciplinary team (including people with lived experience) that reviews frequent suicide attempts of individuals in service. Committee assesses for barriers, engagement, and systemic issues that might impede access to care. This site has a ZS implementation team and ZS Champions team in place since late 2018, and these teams meet regularly. Another site is hoping within the next few months to be moving back into our regular meetings and processes with specific focus to Zero Suicide, ACES and resilience screening. This site commented, "Most in leadership are in meetings from sun up to sun down regarding so many things COVID." A third site reported their ZS implementation team currently lacks focus. *Two sites did not include comments on this metric.*

Survivor Involvement in Planning and Processes	Rating	1	2	3	4	5
What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities?	**3.0**	Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization.	Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports.	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.	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.	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.
Comment or justification for score: **Average score increased from 2.8 to 3.0** Aggregated Comments from Sites in 2021/Winter 2022: One site commented, "We have survivors and people with lived experience with suicide on every facet of our ZS teams. Peer roles are also integrated across our behavioral health programs and are trained to talk with individuals in service about suicide." Another site has several family peer advocates who are open about their experiences, but commented, "many of our clinicians are still reluctant to share due to stigma." A third site intends, although has not at the time of the web survey, to formally onboard a member who has attempted suicide. A fourth site had peer support specialists who were on team, but left recently and have not yet been replaced. *No comment was received from the fifth site for this metric.*						

Element #2: Train

Develop a competent, confident and caring workforce.

Assessment of Workforce Confidence	Rating	1	2	3	4	5
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?	**3.0**	There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.	Clinicians who provide direct patient care are routinely asked to provide suggestions for training.	Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.	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.	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.
Comment or justification for score: **Average score increased from 2.6 to 3.0.** Aggregated Comments from Sites in 2021/Winter 2022: One site has a training matrix for staff positions within their healthcare organization. This site will start offering new trainings to direct care staff within the coming year (i.e. SafeTALK, ASIST, CONNECT, OR Youth SAVE) and working on an an organization-wide training implementation plan. Another site commented, "I must admit, it is time to assess new employees in all roles within our team.". A third site does not have a formal assessment and at least one staff member felt unprepared. *Two sites did not include comments on this metric.*						

Trainings for Non-Clinical Staff	Rating	1	2	3	4	5
What basic training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff?	**4.3**	There is no organization-supported training on suicide care and no requirement for staff to complete training on suicide risk identification.	Training is available on suicide risk identification and care through the organization but not required of staff.	Training is required of select staff (e.g., crisis staff) and is available throughout the organization.	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.	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.

Comment or justification for score: **Average sore increased from 3.4 to 4.3.**
Aggregated Comments from Sites in 2021/Winter 2022: The site using the training matrix commented that all non-clinical staff will follow the training matrix to be able to identify individuals at risk for suicide and follow up with connections to pathways to care. Another site provides Mental Health First Aid, Trauma Informed Care, ACES and Resilience training - generally an online module. Several non-clinical staff members have also completed ASIST training at this site. This site also commented, "Again, we need to catch up with staff hired over the past 13 months." A third site has offered multiple sessions of QPR to non-clinical staff, along with a pre-training survey for everyone. They commented, "Around 40% of staff took the training, but it is required for all staff - we are working to schedule more sessions.". A fourth site reports that all staff with an access badge is required to take suicide prevention training on hire and annually after that. Care access teams have less access to outside trainings, such as ASIST due to budget constraints, and this may have changed for non-clinical staff as well. *No comment was received from the fifth site for this metric.*

Trainings for Clinical Staff	Rating	1	2	3	4	5
What advanced training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff?	**3.8**	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.	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.	Training is required of select staff (e.g., psychiatrists) and is available throughout the organization.	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.	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.

Comment or justification for score: **Average score decreased from 4.0 to 3.8.**
Aggregated Comments from Sites in 2021/Winter 2022: Three sites report using QPR, three reported using CALM, and one uses these in addition to other risk formulation, crisis and safety plans, prevention and intervention, postvention responses including CAMS, DBT, and TF-CBT. This site commented, "Ongoing advanced prevention, intervention, and postvention training will be offered within the coming year." Another site commented their teams have less access to outside trainings such as ASIST because of budget constraints. That site also commented, "There is a gap in training on how to provide suicide specific interventions." *No specific trainings were mentioned in one site's comments for this metric.*

Element #3: Identify

Systematically identify and assess suicide risk among people receiving care.

Screening for Suicide Risk	Rating	1	2	3	4	5
What are the organization's policies for screening for suicide risk?	**4.6**	There is no systematic screening for suicide risk.	Individuals in designated higher-risk programs or categories (e.g., crisis calls) are screened.	Suicide risk is screened at intake for all individuals receiving behavioral health care.	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.	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).
Comment or justification for score: **Average score increased from an average of 3.8 to 4.6.** Aggregated Comments from Sites in 2021/Winter 2022: Metric: One site reported 100% of new enrollments over the age of 11 were screened for suicide risk. Screenings for individuals 11 years and younger are given only when indicated by caregiver, during intake, or when clinically appropriate at this site. At another site, 100% of clients (13 out of 13) were screened for suicide risk. A third site is adding pathways to care for re-screening/ongoing assessment to their new EHR program, and the fourth site has the ultimate goal of 100% of clients enrolled to be screened for suicide risk, but is currently at 47%. This site commented: "Of course, our well checks have dropped tremendously" presumably because of the COVID-19 pandemic. The fifth site screens at intake, during transitions to other departments, at discharge and twice/day in the Psychiatric Emergency Service (PES) and in-patient units. All providers do a daily screening/assessment at that site.						

Screening Tools Used	Rating	1	2	3	4	5
How does the organization screen for suicide risk in the people it serves?	**4.8**	The organization relies on the clinical judgment of its staff regarding suicide risk.	The organization developed its own suicide screening tool but not all staff are required to use it.	The organization developed its own suicide screening tool that all staff are required to use.	The organization uses a validated screening tool that all staff are required to use.	The organization uses a validated screening tool and staff receive training on its use and are required to use it.
Comment or justification for score: **Average score increased from 4.4 to 4.8.** Aggregated Comments from Sites in 2021/Winter 2022: Three sites use PHQ2/9 and four use C-SSRS. One site uses CRAFFT. All five sites use at least one validated screening tool. One site uses functional behavior assessments to assess for high risk behavior in some programs. At one site screenings will be implemented into EHR pathways to care when their EHR is implemented. Ensuring that all patients receive screenings is included is another site's KPI.						

Suicide Risk Assessment	Rating	1	2	3	4	5
How does the organization assess suicide risk among those who screened positive?	**4.4**	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.	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.	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.	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.	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.
Comment or justification for score: **Average score remained the same at 4.4.** Aggregated Comments from Sites in 2021/Winter 2022: Four of the five sites were unable to provide specific numbers for this metric in 2021. One site is still in development phase of tracking attempts, demographics, and follow-ups. This site plans to use their new EHR to develop new pathways to care for all of the above touchpoints of suicidality. Another site recently moved to a new EHR and was unable to pull the information at the time of the web survey. A fourth site commented, "**Of the 2,221 people who screened positive for suicide risk in the past full month (March 2021), 150 received a comprehensive risk assessment on the same day as the screening."** A fifth site recorded that 100% of those who screened positive for suicide risk had a comprehensive risk assessment completed on the same day, but the method of arriving at 100% was not clear.						

Element #4: Engage

Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet patient needs.

Care for Patients At Risk for Suicide	Rating	1	2	3	4	5
Which best describes the organization's approach to caring for and tracking people at risk for suicide?	**3.7**	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.	When suicide risk is detected, the care plan is limited to screening and referral to a senior clinician.	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.	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.	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.
Comment or justification for score: **Average score increased from 3.3 to 3.7.** Aggregated Comments from Sites in 2021/Winter 2022: One site commented, "We have draft protocols for department-wide suicide care, but policies and procedures are being developed to fully implement the process. ZS Program Coordinator will draft recommendations for policy and procedure implementation. EHR will provide streamlined system to track pathways to care that individuals access." A second site reported suicide care management plan documentation exists but is not integrated into EHR and there may not be a specific timeframe for holding case conferences. Three sites did not include comments for this metric.						

Collaborative Safety Planning	Rating	1	2	3	4	5
What is the organization's approach to collaborative safety planning when an individual is at risk for suicide?	**3.8**	Safety planning is neither systematically used by nor expected of staff.	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.	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.	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.	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.

Comment or justification for score: **Average score increased from 2.8 to 3.8.**

Aggregated Comments from Sites in 2021/Winter 2022: Specific numbers for this metric were not available from three of the five sites at the time of the web survey. Two sites did not name the safety plan used; three sites named the Stanley/Brown template. One site has identified a single safety plan they intend to implement in every program, but right now each program can use their chosen plan. The current practice at this site is to develop comprehensive safety plan on the same day that individuals screen positive for suicide risk, but, "we do not have a tracking system for this yet again, EHR will support this." Another site commented, "The frequency of safety plan review depends on the level of care and significance of suicidal ideation." The agency expectation is 100%, but their current EHR does not support this report. Another site reported they are not sure if everyone is using the form nor whether everyone is trained on how to create a collaborative safety plan and that the plan is shared with consent. The only site that provided specific data for this metric reported: **7% of the 2,221 clients who screened positive for suicide risk during the past full month (May 2021) had a safety plan developed on that same day. This site also reported in 2019 that 85% of the 40 clients who screened and assessed positive for suicide risk during the past full month (July 2019) had a safety plan developed on that same day.**

Collaborative Means Restriction	Rating	1	2	3	4	5
What is the organization's approach to lethal means reduction?	**4.0**	Means restriction discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means restriction counseling is rarely documented.	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	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.	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.	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.
Comment or justification for score: **Average score increased from 3.8 to 4.0.** Aggregated Comments from Sites in 2021/Winter 2022: None of the five sites reported the percent of clients who assessed positive for suicide risk during the past full month who were also counseled about lethal means on that same day. One site commented that their new EHR would support pulling these data and another site commented while the number counseled on access to lethal means on the same day they screened positive for suicide risk is unknown, the date of their positive screen is on their safety plan. A third site commented, "Internally there are strong protocols around limiting lethal means, but it may still rely on individual clinician judgement. Unknown whether family is contacted in all cases." Comments were not received from two of the five sites.						

Element #5: Treat

Use effective, evidence-based treatments that directly target suicidality.

Treatment Approach	Rating	1	2	3	4	5
What is the organization's approach to treatment of suicidal thoughts and behaviors?	**3.8**	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.	The organization may use evidence-based treatments for some psychological disorders, but it does not use evidence-based treatments that specifically target suicide.	Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practices.	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.	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.
Comment or justification for score: **Average score increased from 3.2 to 3.8.** Aggregated Comments from Sites in 2021/Winter 2022: One site reported that 100% of clinical staff trained in CAMs, CBT-SP, and/or DBT, another site reported 80% of clinical staff are trained in a specific suicide treatment model (CBT-SP and DBT), a third site does not track staff training (although they commented that 15% of staff are trained in CAMS and DBT) and a fourth site did not include comments on this metric. The fifth site does not support consistent training. One site commented, **"**We have methods to sustain our training, but have found it difficult at times to train all incoming staff, due to the significant amount of required trainings already in place. We appreciate the CAMS model, but have found the training to be expensive and unfortunately difficult to coordinate."						

Element #6: Transition

Provide continuous contact and support, especially after acute care.

Engaging Hard to Reach Patients	Rating	1	2	3	4	5
What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't show for appointments?	**3.7**	There are no guidelines specific to reaching those at elevated suicide risk who don't show for scheduled appointments.	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.	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.	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.	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.
Comment or justification for score: **Average score increased from 2.9 to 3.7.** Aggregated Comments from Sites in 2021/Winter 2022: None of the five sites have a formalized process around follow-ups or engagement for hard to reach patients, and this metric is not relevant for one site. One site uses Caring Contacts and other outreach efforts (phone calls, texts, home visits) are clinically indicated for staff to use in attempts to reach a high-risk individual. This site reports that their new EHR will provide standardized method of outreach for all programs. Another site commented, "Our clinicians do a good job reaching out to clients after no-show appointments, but the process is not formalized." No detailed comments were received from two sites.						
Follow-up after Discharge	**Rating**	**1**	**2**	**3**	**4**	**5**
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)?	**3.5**	There are no specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings.	The organization requires follow-up for individuals with suicide risk, but the parameters and methods are up to the individual clinician's judgment.	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.	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.	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.
Comment or justification for score: **Average score increased from 3.4 to 3.5.** Aggregated Comments from Sites in 2021/Winter 2022: One agency's practice is to follow up with any client discharged from a hospital to the provider within 24 hours, but this is not codified in policy. Another site has guidelines in place that an individual is seen by their clinical staff within 7 days of discharge from hospital/ED/other acute setting, and commented, "ideally this happens sooner than that. Review of safety plan is encouraged to reflect most recent clinical recommendations upon discharge. Will be creating streamlined approach for supporting individuals after discharge from each higher level of care." A third site reports using caring contacts according to agency guidelines, but that there are no available staff to complete the tasks.						

Element #7: Improve:

Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes & better care for those at risk.

Analysis of Suicide Deaths	Rating	1	2	3	4	5
What is the organization's approach to reviewing deaths for those enrolled in care?	**3.2**	At best, when a suicide or adverse event happens while the client is in treatment, a team meets to discuss the case.	Root cause analysis is conducted on all suicide deaths of people in care.	Data from all root cause analyses are routinely examined to look at trends and to make changes to policies.	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.	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.

Comment or justification for score: **Average score increased from 2.5 to 3.2.**
Aggregated Comments from Sites in 2021/Winter 2022: One site commented, "Senate Bill 561 coordinator responds to deaths by suicide of individuals ages 24 and younger according to state protocol. Currently no adult protocol. All deaths (both by suicide and other causes) of individuals in service are reviewed by incident review committee. Incident reports indicate systemic improvement suggestions based on root cause analysis." Another site commented that they experience difficulty obtaining information about clients who have discharged from their services. A third site commented, "We have a process in place to formally review all adverse incidents" and continued: Suicides while in care are rare. If we know about a suicide in the 30 days following discharge, we do a root cause analysis and policy changes may also result. When root cause analysis is conducted, changes to policies do occur. We do look at trends in self-harm events, including suicide attempts, on a monthly basis. *The remaining two sites did not include comments.* ***Root cause analysis metrics were only reported by one site, which commented, "The most recent date of a root cause analysis of a suicide death was in 2016". None of the five sites reported the date and number of days since most recent suicide death (a) of someone in care nor (b) of someone who had left care less than 6 months before suicide death.***

Tracking Suicide Deaths	Rating	1	2	3	4	5
What is the organization's approach to measuring suicide deaths?	**2.8**	The organization has no policy or process to measure suicide deaths for those enrolled in their care.	The organization measures the number of deaths for those who are enrolled in care based primarily on family report.	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.	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.	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.

Comment or justification for score: **Average score increased from 2.4 to 2.8.**
Aggregated Comments from Sites in 2021/Winter 2022: One site commented that their SB 561 coordinator has tracked deaths by suicide for individuals ages 24 and younger since 2016 and deaths of adults in care are tracked by incident review committee tracking deaths for over 20 years as part of the agency's policies. None of the other four sites reported the date measurement for suicide deaths was established, nor the date of the most recent annual crosswalk of enrolled patients against vital statistics data. One site commented, "We have very few deaths of clients in care (thankfully). Again, we struggle to obtain data for clients who have left services." Another site reported they do not follow patients post discharge so they don't have 30- or 60-day data; they only do a caring contact. *The other two sites did not include comments on this metric.*

Continuous Quality Improvement (CQI)	Rating	1	2	3	4	5
What is the organization's approach to quality improvement activities related to suicide prevention?	**3.5**	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.	Suicide care is discussed as part of employee training and by those in supervision in clinical settings.	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.	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.	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.

Comment or justification for score: **Average score decreased from 3.6 to 3.5.**
Aggregated Comments from Sites in 2021/Winter 2022: One site reported their most recent date that data from EHR or chart reviews were examined for adherence to suicide care policies was January, 2021, but none of the other four sites reported a date for this metric. Another site commented, "Suicide Attempt Review Committee was developed to provide timely and intentional responses to frequent suicide attempts by individuals in service. EHR system will support pathways to care to further implement suicide care in a streamlined, consistent manner across our programs." A third site reported some monthly audits occur in the PES. *The other two sites did not include comments on this metric.*

Background:

This implementation self-assessment and the accompanying web survey were adapted for the Oregon Health Authority (OHA) by Portland State University in collaboration with the OHA Youth Suicide Prevention staff under a 2014-2019 Garrett Lee Smith Youth Suicide Prevention Grant (SAMHSA Grant #1H79SM061759). The assessment was adapted from three existing Zero Suicide resources available at http://zerosuicide.org/.

- **The Organizational Self-Study** is a questionnaire about the extent to which each component of the Zero Suicide approach is in place at a single organization. Zero Suicide recommends completing this self-study at the start of an organization's Zero Suicide initiative, then every 12 months after that as a measure of fidelity to the model. **The self-study questions serve as the basis for this Oregon Zero Suicide Implementation Assessment and have been reformulated as indicators**. The response options (or anchors) for each question are included in the grid to define the level of implementation for each indicator.
- **The Data Elements Worksheet** contains primary and supplemental measures recommended for behavioral health care organizations to strive for to maintain fidelity to a comprehensive suicide care model. The supplemental measures are clinically significant but may be much harder to measure than the primary measures. Zero Suicide recommends reviewing these data elements every three months in order to determine areas for improvement. **Starting with element #3 (Identify) of this implementation assessment, these data points are requested for each relevant indicator as documentation for the rank awarded.**

OHA is using this implementation assessment to track change over time related to suicide prevention efforts among organizations statewide as part of Cooperative Agreements to Implement Zero Suicide in Health Systems project (2020 – 2025). Funding is provided by SAMHSA Grants to Implement Zero Suicide in Health Systems Grant (Grant # 1H79SM083398) awarded to the Oregon Health Authority between August 2020 and August 2025.

For more information on:

--Zero Suicide, visit http://zerosuicide.org/

--OHA's Zero Suicide Initiative, contact Megan Crane, OHA Zero Suicide Coordinator in the Oregon Health Authority's Injury and Violence Prevention Section at meghan.crane@dhsoha.state.or.us

--The study being conducted using this instrument, contact Karen Cellarius, Senior Research Associate, Portland State University Regional Research Institute for Human Services at cellark@pdx.edu