



Zero Suicide: From Planning to Lessons Learned

Mikelle Moore

Senior Vice President, Community Health

Carolyn Tometich

Executive Clinical Director, Behavioral Health

Helping people
live the
healthiest lives
possible®



Meeting Local Health Challenges

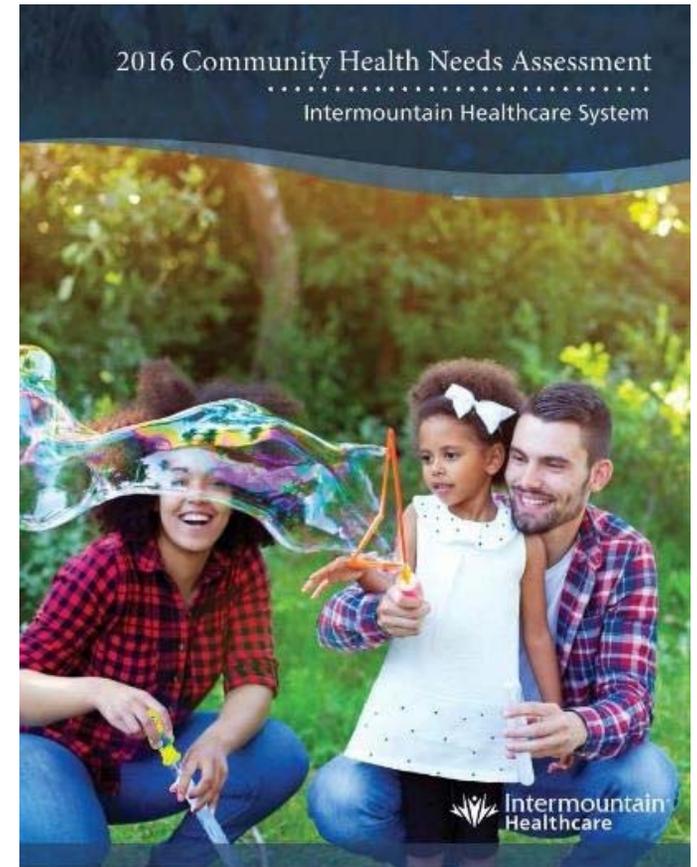
- Conducted Health Needs Assessments for 23 hospitals
- The significant health priority is **prevention** in four key areas:
- Proud to be engaged in community efforts

Prediabetes

High
Blood
Pressure

Depression/
Suicide
Prevention

Prescription
Opioid
Misuse



Quick Facts About Intermountain Healthcare

Headquartered in
Salt Lake City

37,000
employees

470+
Volunteer
trustees serving
on 32 boards

Created in
1975
when
LDS Church
donated its 15
hospitals to the
communities
they served

\$225 million in charity care during
2017 (236,446 cases)

23
hospitals
with 2,772
licensed beds

Integrated Health System
Serving primarily Utah and Southern Idaho

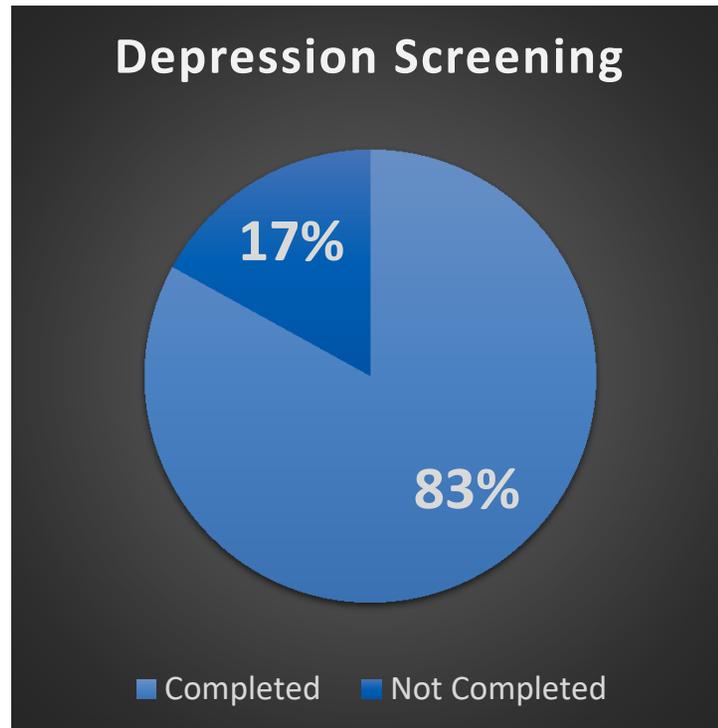
2,300
employed
physicians and
APCs at more
than
185
clinics

SelectHealth
insurance
plans
with
850,000
members

TeleHealth
Homecare
& Hospice
InstaCare
Connect Care
Life Flight
Precision
Genomics

Strong Bond Agency Ratings
S&P: **AA+** Moody's: **Aa1**

Evidence-based Care



INTERMOUNTAIN HEALTHCARE

Suicide Prevention

This care process model (CPM) was developed by Intermountain's Behavioral Health Clinical Program. Informed by guidelines from the American Association of Suicidology and the Center for Suicide Risk Assessment at Columbia University Medical Center, this CPM provides guidance for prevention, assessment, and treatment for patients with suicidal thoughts, feelings, or behaviors. This CPM focuses on prevention and treatment in primary care, emergency departments, and hospitals, though may also be applied to other clinical environments.

► Why Focus ON SUICIDE RISK?

- **Suicide is a leading cause of preventable death in Utah.**^{VIPP} An average of 501 Utahns die from suicide, and 3,698 Utahns attempt suicide each year.^{VIPP} According to the CDC, Utah adults have the highest incidence of suicidal thoughts in the U.S. — 6.8% of Utah adults reported having suicidal thoughts during 2008–2009; the national average during the same period was 3.7%.^{CRO}
- **Primary care providers (PCPs) and mental health (MH) providers are positioned to help.** A significant portion of patients who died by suicide visited healthcare providers in the year before they died by suicide (see table at right).^{AEM} Screening for suicide could help identify patients at risk and reduce suicide in our community.
- **Many Utahns who died by suicide had an addictive substance in their system.** According to the 2012 Utah Toxicology Report, the most common substances found in victims who died by suicide fell into the "other" category (43.9%),

TABLE 1: Percent of patients who visited a PCP or MH provider before suicide^{AEM}

Patients	PCP		MH provider	
	1 month	1 year	1 month	1 year
All	45%	77%	19%	32%
<35 years	23%	62%	15%	24%
>55 years	58%	77%	11%	8.5%

► WHAT'S INSIDE?

- THE C-SSRS 2
- ALGORITHMS AND TREATMENT GUIDELINES
- Clinic care 4
- Emergency care 6
- Inpatient care 8
- PREVENTION AT INTERMOUNTAIN 10
- UNIFORM TERMINOLOGY 11
- RISK AND PROTECTIVE FACTORS 12
- SPECIAL POPULATIONS 14
- CONSIDERATIONS FOR CARE 16
- Tips for facilitating a referral 16
- Safety plans 16
- Non-suicidal self injury 17
- Involuntary commitments 17
- PHARMACOTHERAPY 18
- REFERENCES 19

Reducing access to lethal means

Zero Suicide Organizational Self-Study

Zero Suicide Self-Study Results



- Scores of 1
- Scores of 2
- Scores of 3
- Scores of 4

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.

<input type="radio"/>	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.
<input type="radio"/>	2	The organization has 1-2 formal processes specific to suicide care.
<input type="radio"/>	3	The organization has written processes specific to suicide care. They have been developed for at least 3 different components of Zero Suicide.
<input type="radio"/>	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.
<input type="radio"/>	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.

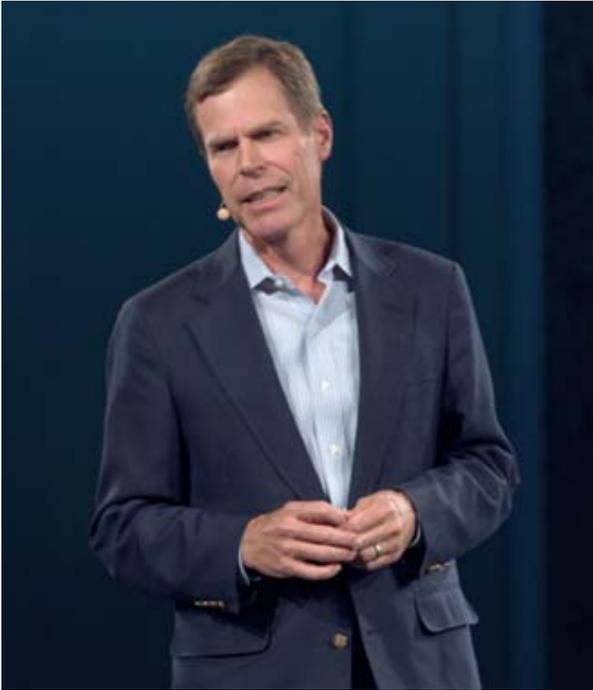
If you wish to describe or elaborate on this item, please do so in the space provided below. (Character limit: 1,000)

The Suicide Assessment and Prevention Care Process Model (CPM) was implemented November 2014. Implementation included training in a variety of settings for providers and caregivers. This CPM standardizes the processes and tools used across the System. The Columbia-Suicide Severity Rating Scale (C-SSRS) was implemented as the standard tool to be used in all settings including emergency department, inpatient medical, behavioral health inpatient units, and outpatient clinics when patients are identified at risk for suicide (generally from PHQ-9/A question 9). Training is completed on the C-SSRS upon hire for all nursing staff.

to establish guidelines and promote the policies as well as staff training in the

Additional Comments (Character limit: 120)
Consider increasing screening opportunities in the acute care setting.
inconsistently
(an locks were provided but inconsistently offered. Discussing using the CALM program to intervene further.
- training to crisis and inpatient units
Minimal training has been completed, even in our outpatient specialty clinics.
Need comprehensive strategy

Leading together to achieve ZERO Suicide



Succeeding in ZERO Suicide

- Accountability and concrete action are needed
- Clear roles and a strong team are needed
- Account for the complexity of collaboration and of preventing suicide
- Pursue some short-term wins





Kristi Shepherd

Patient Services Representative,
Sevier Valley Clinic

ZERO Suicide Heroes

Collin Searle

Lisa Ly

Chantelle Turner

Communications Team Members



ZERO ~~9~~ ~~10~~ ~~11~~ ~~12~~ ~~13~~ ~~14~~ ~~15~~ ~~16~~ ~~17~~ ~~18~~ ~~19~~ ~~20~~ ~~21~~ ~~22~~ ~~23~~ ~~24~~ ~~25~~ ~~26~~ ~~27~~ ~~28~~ ~~29~~ ~~30~~ ~~31~~ ~~32~~ ~~33~~ ~~34~~ ~~35~~ ~~36~~ ~~37~~ ~~38~~ ~~39~~ ~~40~~ ~~41~~ ~~42~~ ~~43~~ ~~44~~ ~~45~~ ~~46~~ ~~47~~ ~~48~~ ~~49~~ ~~50~~ ~~51~~ ~~52~~ ~~53~~ ~~54~~ ~~55~~ ~~56~~ ~~57~~ ~~58~~ ~~59~~ ~~60~~ ~~61~~ ~~62~~ ~~63~~ ~~64~~ ~~65~~ ~~66~~ ~~67~~ ~~68~~ ~~69~~ ~~70~~ ~~71~~ ~~72~~ ~~73~~ ~~74~~ ~~75~~ ~~76~~ ~~77~~ ~~78~~ ~~79~~ ~~80~~ ~~81~~ ~~82~~ ~~83~~ ~~84~~ ~~85~~ ~~86~~ ~~87~~ ~~88~~ ~~89~~ ~~90~~ ~~91~~ ~~92~~ ~~93~~ ~~94~~ ~~95~~ ~~96~~ ~~97~~ ~~98~~ ~~99~~ ~~100~~ ~~101~~ ~~102~~ ~~103~~ ~~104~~ ~~105~~ ~~106~~ ~~107~~ ~~108~~ ~~109~~ ~~110~~ ~~111~~ ~~112~~ ~~113~~ ~~114~~ ~~115~~ ~~116~~ ~~117~~ ~~118~~ ~~119~~ ~~120~~ ~~121~~ ~~122~~ ~~123~~ ~~124~~ ~~125~~ ~~126~~ ~~127~~ ~~128~~ ~~129~~ ~~130~~ ~~131~~ ~~132~~ ~~133~~ ~~134~~ ~~135~~ ~~136~~ ~~137~~ ~~138~~ ~~139~~ ~~140~~ ~~141~~ ~~142~~ ~~143~~ ~~144~~ 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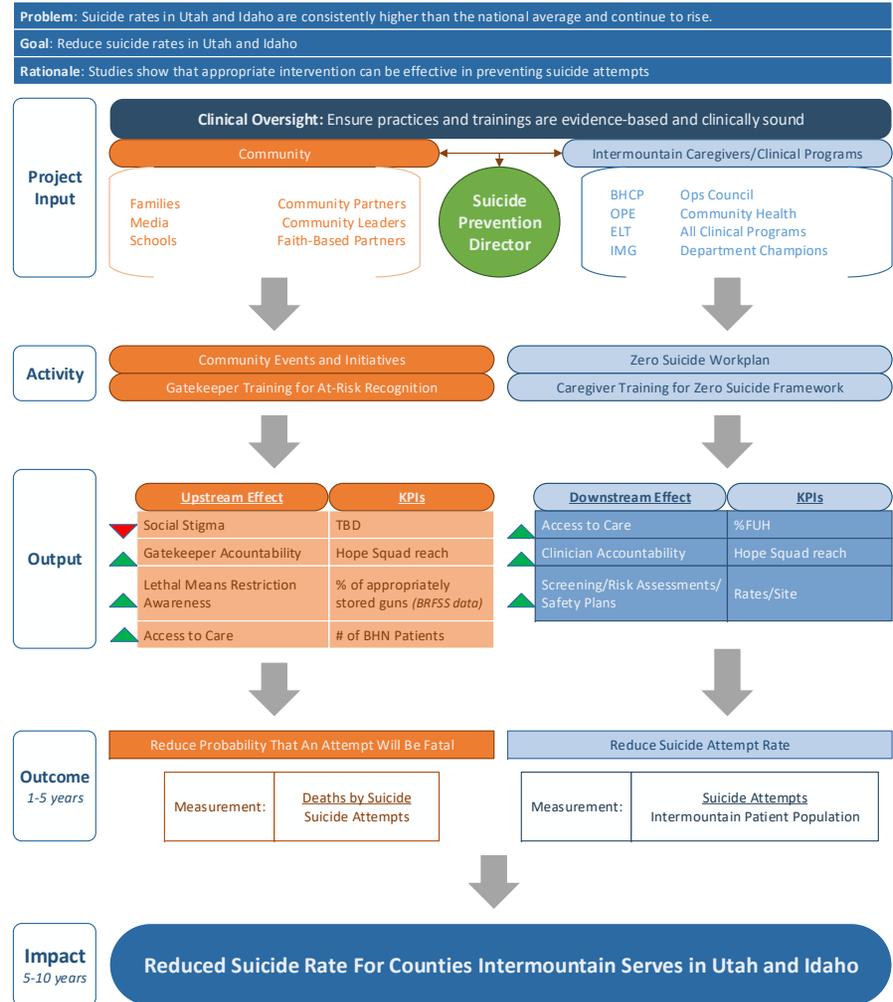
Framing the Work



Intermountain Operating System



Developing a Logic Model





**Intermountain
Healthcare**

Healing for life®