Zero Suicides in Healthcare
Our Challenge

August 2011

Develop a Clinical Pathway for Suicide Prevention

Centerstone Enterprise

(Indiana and Tennessee)
Research
Best Practice

Evaluate → Screen → Assess → Treat

Monitor

CENTERSTONE

News and Research

Depression Care Program Eliminates Suicide

By Mary Sarg, PhD
March 10, 2008

A new program for patients with depression has resulted in a significant reduction in suicide rates at Henry Ford Health System.

The program, called the Depression Care Program (DCP), was developed to increase access to mental health services for patients with depression. The program has been in place for five years and has resulted in a 75% reduction in suicide rates compared to the national average.

The results of the program are significant, as suicide is the leading cause of death among people with depression. The program has been widely recognized as a model for improving mental health care and has been adopted by other health systems across the country.

The success of the program is due to the commitment of the entire staff at Henry Ford Health System to providing compassionate and effective care to patients with depression. The program has also been praised for its innovative approach to mental health care, which includes a combination of medication, therapy, and support services.

Some of the key features of the program include:

- A dedicated team of mental health professionals
- A focus on primary care providers
- A comprehensive approach to treatment

The program has been successful in improving outcomes for patients with depression and has received recognition from national organizations.

The Henry Ford Health System is committed to providing the best possible care for patients with depression and other mental health conditions. The Depression Care Program is one example of the system's commitment to excellence in mental health care.
Suicide Prevention Committee

- Center for Clinical Excellence (CRI)
- Suicide Pathway Charter
- Project Plan
- Planning Worksheet

- Approval from Executive Leadership
- Commitment from Executive Leadership
- Pilot Program (TN)
Leading Advocacy

Mike Hogan and Bob Vero

Testifying before Congress

Senate HELP Committee
National Responsibility

- U.S. Surgeon General’s Office
- National Action Alliance for Suicide Prevention
- Education Development Center
- Suicide Prevention Resource Center
Zero Suicides in Healthcare

National Collaboration
Arizona (Magellan), Kentucky (DMH), New York (DMH), & Texas (DMH)
Providers Join National Collaborative

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Voice of Providers

- Centerstone – Illinois, Indiana, Kentucky and Tennessee
- Group Health Cooperative – Washington State
- Institute for Family Health – New York
Zero Suicide in Healthcare
Not another life to lose

What is Zero Suicide in Health and Behavioral Health Care?

Over the decades, there have been many instances where individual mental health clinicians have made heroic efforts to save lives, but systems of care have done very little. Two exceptions are Henry Ford Health System and Magellan Health Services of Arizona. The 2011 report Suicide Care in Systems Framework describes the Henry Ford and Magellan successes and asserts that suicide intervention and care must be defined as a core business competency and expectation for community behavioral health.

Suicide Care in Systems Framework was developed by the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention. Task Force co-chairs David Corrington, vice president for Youth & Adult Services at Magellan of Arizona, and Mike Hogan, then commissioner of mental health for the state of New York, strongly believe that organizations and systems must work to make suicide a “never event” in programs and systems of care.

http://www.zerosuicide.com

Zero Suicide in Healthcare Toolkit

www.zerosuicide.com
National Action Alliance

Clinical Care & Intervention Taskforce

Essential Dimensions of Suicide Prevention in Healthcare Systems

- Create a Culture
- Pathways to Care
- Competent Workforce
- Identify/Absess Suicide Risk Level
- Use Evidence Based Care
- Continued Contact After Care
Zero Suicide Movement

National Explosion of Interest and Adoption
Zero Suicide Task Force

- National Action Alliance
  Appointed: Advisory Group & Data Panel

- Advisory Group – Becky Stoll

- Data Panel – Becky Stoll, Brad Nunn and Jennifer Lockman

- Zero Suicide Academy - June 2014 Washington DC

- Tennessee Suicide Prevention Network

- Faculty/Mentor – Becky Stoll
International Collaborative

Ireland, Netherlands, New Zealand, Northern Ireland, United States
Zero Suicide
Clinical Pathway for Suicide Prevention
Clinical Pathway
Suicide Prevention

- Organizational Readiness
- Workforce Survey
- Communication Plan – Internal & External
- Adoption of “Zero Suicide” Culture
- Training Program
Indiana
Tennessee

Current Components
“Clinical Pathway for Suicide Prevention”

- Electronic Health Record
- Screening/Assessment
- Frequency of Contact
- Monitoring
- Quality Assurance
- Evaluation
Columbia Suicide Severity Rating Scale

Dr. Kelly Posner – Columbia University
Screening & Assessment

• Ages 12 and older
• All service lines
• At every service delivery point
• Some provisions on frequency for daily programs
• Embedded in Electronic Health Record
• Recommendation based on response
Placement in the Pathway

Education Sheet

- Reviewed with the client
- Outlines components of the Pathway
- Acknowledgment from client
- Commitment from client

Crisis Management Plan

- Triggers
- Supports
- Reduction of access to means
- Coping strategies
- Resources
Frequency of Contact

- Guideline - 1X per week for an in person therapy session
- Refer those who are not in therapy
- Continue to assess and refer, as appropriate, those who refuse therapy services
Monitoring

Suicide Pathway Clients Who Do Not Show

Populate on Crisis Call Center’s “High Risk Follow Up” List
Electronic Health Record

- Screening/Assessment Tool (mandatory)
- Education Sheet & Crisis Management Plan (mandatory)
- Suicide Pathway clients display in “red”
- Blast email to providers when enrolled/removed
- Intake question on weapons in home
- Intake question on access to internet/devices
- Safety functionality for Suicide Pathway clients who DNS
Oversight

Quality Assurance

- Definition of who counts as a “client” in suicide rates
- Confirmation of death as a suicide (medical examiner reports)
- Monthly analysis of attempts & completions
- Fidelity monitoring

Evaluation

- Use of Centerstone Research Institute
- Study of “High Risk Follow Up” (BC/BS of TN Foundation)
- Contract with SPRC
- Need for funding
Suicide Prevention

“Baking It Into Our System”
Continued Culture Growth
Training Program
Engagement
Treatment Modalities
Expertise of “Lived Experience”
Interface with PCPs
Post Suicide Response
Further Report Development
Further EHR Development
Robust Suicide Pathway

Several years of work to do

Focus on developing best practice

Will begin to inject new developments

Rolling in Illinois
Suicide Prevention Outcomes

Reported Suicides per Month

CENTERSTONE
Suicide Prevention Outcomes

Reported Suicides per Rolling 12 Month Period


0  2  4  6  8  10  12  14  16  18
Suicide Prevention
Outcomes

Annual Suicides per 10,000 Clients Seen
(Rolling 12 months)
Zero Suicides in Healthcare

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