## Zero-Suicide Organizational Self-Assessment Gap analysis

| APPROACH | CURRENT STATE | 4/15/2018 RATING 1-5 | 4/1/2019 RATING 1-5 | Goal | Ideal State |
|---|---|---|---|---|---|
| 1. What type of committement has leadership made to reduce suicide and provide safer sucide care? | The organization has written process specific to suicide care. They have been developed for at least 3 different components of Zero Suicide. | 3 | 3 | 5 | Processes address all components of Zero Suicide listed above. Staff receives annual training on processes and when new ones are introduced. Process are reviewed and modified annualy as needed. |
| 7. What type of formal commitment has leadership made through staffing to reduce suicide and provider safer suicide care? | The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for deveoping guidelines and sharing with staff. | 3 | **4** | 5 | The Zero suicide implementation team meets regularly and is multidisciplinary. Staff members erve on the team for terms of one to two years. The team modifies processes based on data review and staff input. |
| 8. What is the role of suicide attempt and loss survivors in the organizations design, implementation, and improvement of suicide care policies and activities? | Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as seving as volunteers or peer supports. | 1 | **2** | 5 | Suicide attempt and loss survivors participate in a variety of suicide prevention activies within the organization, such as sitting on decision-making teams or boards, participating in policy decisions, assisting with employee hiring and training, and particpating in evaluation and quality improvement. |
| 9. 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? | There is no formal assessment of staff on their perception of confidence and skills providing suicide care. | 1 | 1 | 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 weakenesses. |
| 10. What basic training on identifying people at risk for suicide or providing suicide care has been provided to non-clinical staff? | There is no organization-supported training on suicide care and no requirement for staff to complete training on suicide risk identification. | 1 | 1 | 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. |
| 11. What advanced training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff? | Training is required of select staff (e.g., psychiatrists) and is available throughout the organization. | 2 | **3** | 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. |
| 12. What are the organizations policies for screening for suicide risk? | Suicide risk is screened at intake for all individuals receiving behavioral health care. | 3 | 3 | 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). |
| 13. How does the organization screen for suicide risk in the people it serves? | The organization developed its own suicide screening tool but not all staff are required to use it. | 2 | 2 | 5 | The organization uses a validated screening tool and staff receive training on its use and are required to use it. |
| 14. How does the organization assess suicide risk among those who screened positive? | All individuals with risk identified, either at intake screening or at any other point during care, are assessed by clinicans who use validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors. | 4 | 4 | 5 | A suicide risk assessment is com[pleted 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. |
| 15. Which best describes the organizations approach to caring for and tracking people at risk for suicide? | All providers are expected to provide care to those at risk for suicide. The organziation has guidance for care amanagement for individuals at different risk levels, including frequency of contact, care planning, and safety planning. | 3 | 3 | 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 implmentation team. |
| 16. What is the organization's approach to collaborative safety planning when an individual is at rrisk for suicide? | Safety plans are expected for all individuals with 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. | 2 | **4** | 5 | A stafety 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 morst formal or restrictive. Other clinicans 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. |
| 17. What is the organzization's approach to lethal means reduction? | 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. | 3 | 3 | 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 reviwed regularly while the indiviual is at an elevated risk. |
| 18. What is the organization's approach to treatment of suicidal throughts and behaviors? | Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practice. | 1 | **3** | 5 | The organization ahs invested in evidenced-based treatments for suicide care (CAMS, CBT-SP or DBT), with designated staff receiving trainin in these models. The organization has a model for ustaining 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. |
| 19. What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't show for appointments? | There are no guidelines specific to reaching those at elevated suicide risk who don't show for scheduled appointments. | 1 | 1 | 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 wiht the person within eight hours of the missed appointment. The organization has approaches, such as peer supports, peer-run crisis respirt, home visits, or drop-in appointments, to address the needs of hard-to-reach patients. |
| 20. what is the organization's approach to following up on patients who have recently been discharged from acute care settings (ED, Inpatient psych)? | There are not specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings. | 1 | 1 | 5 | Organizational guidelines are in place that address follow-up after crisis contact, no-shows, transition from an ED, 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. |
| 21. What is the organization's approach to reviewing deaths for those enrolled in care? | 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. | 4 | 4 | 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 suiicde attempts requirement medical attention. Policies and training are updated a s result. |
| 22. What is the organization's approach to measuring suicide deaths? | The organization has not policy or process to measure suicide deaths for those enrolled in their care. | 1 | 1 | 5 | The organization annually crosswalks enrolled patients (e.g., from claims database) against state vital statistics data to determine the number of deaths for those enrolled in care. The organization tracks suiicide deaths among clients for up to 6 months past case closed. |
| 23. What is the organization's approach to quality improvement activites related to suicide prevention? | 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 HER or paper record. | 2 | **3** | 5 | Suicide care is entireley embedded in HER. Data from HER or chart reviews are routinely examined (atleast every 2 months) by designated team to determine that staff are adhering to suicide care policies and to access for reductions in suicide. HER clinical workflows or paper records are updated regularly as the team reviews data and makes changes. |
| | **Score** | **38** | **46** | **90** | |
| | **% Gap Identified** | 57.8 | 48.9 | | |