ICSI and MDH Zero Suicide Learning Collaborative

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FINAL REPORT

Background and Approach

In 2020 ICSI launched a new collaborative opportunity for healthcare systems in partnership and with support from the Minnesota Department of Health (MDH), organized around the Zero Suicide framework. This new learning collaborative provided an opportunity for participating healthcare organizations to build from work they'd done together previously with ICSI, addressing suicide prevention and intervention in emergency departments (EDs) as part of the MN Health Collaborative (See the ED Shared Standards here). These leaders were interested in spreading the expertise gained to implement changes in other parts of their systems, and/or wanted to continue to implement more changes in their EDs.

Seven large healthcare delivery and integrated systems, from both rural and metro areas of Minnesota participated in the Zero Suicide Collaborative for the full year. These include Allina Health, CentraCare Health, Essentia Health, HealthPartners, Hennepin Healthcare, North Memorial Health, and the Veterans Administration of Minneapolis. The group met monthly, holding two-hour meetings constructed with educational presentations for the first hour and a second hour reserved for each of the teams to meet with one another to forward their own organizational work.

This collaborative took place during the thick of the COVID-19 pandemic, which presented some challenges. In fact, ICSI's Mental Health Steering Committee, made up of mental health leaders from the above organizations as well as others, deliberated as to the timing of this effort. Ultimately, the increased demand for mental health and substance use disorder services reported by all organizations resulted in their making suicide prevention and intervention a priority.

The teams have reported that the focused collaborative meetings and dedicated time to meet as teams helped them make progress in their implementation efforts. Several have expressed a sense of amazement that they had been able to advance this work despite the pressures of the pandemic.

The value of working together as a cohort over time has been strongly illustrated in this effort. The group had already established with ICSI a culture of focused effort and a culture of learning together, generously sharing about best practices as well as being transparent about challenges. This also created an environment of positive peer pressure for action: Working together as a collaborative elevates the importance of addressing suicide prevention and intervention as people see that "others are doing it." The teams reported that the collaborative has also aided decision-making by leadership in different organizations regarding choosing evidence-based tools, as well as spreading valuable, practical implementation guidance across peers.

This cohort is continuing to meet for a second year with facilitation and leadership from MDH.

Implementation Progress

We analyzed data provided by six organizations who completed an organizational self-study at the beginning of the collaborative and again after a year, in addition to information gained by semi-structured report-outs and interviews provided at six months and again at the conclusion of the collaborative.

As a cohort, health systems made the most progress in the following areas:

- Screening
- Safety planning
- Training non-clinical staff
- Support for ongoing quality improvement

These healthcare delivery systems implemented changes in different settings based on where they had the most need and opportunity for improvement. All continued to advance their ED work, while all but one also branched out to improving practices in other settings. Three organizations implemented changes in primary care/ambulatory settings, and three focused on inpatient (one of these organizations focused on both inpatient and primary care/ambulatory settings).

More specific information on progress follows, organized within the Zero Suicide framework.

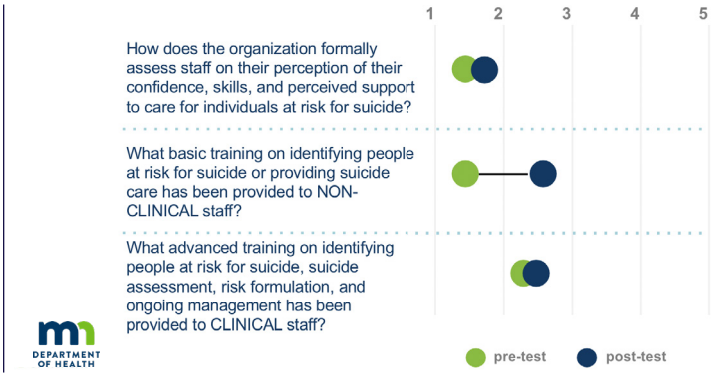
Element 1: Lead system-wide culture change committed to reducing suicides

When this collaborative began, leadership commitment for reducing suicide was already fairly significant across several of the organizations, as evidenced in their prior work with ICSI and desire to work together further. For a few, leadership commitment heightened during the pandemic as the demand for mental health and substance use disorder services increased. However, the strain of the pandemic on healthcare resources and staffing did affect implementation efforts in most of these organizations.

Element 2: Train a competent, confident, and caring workforce

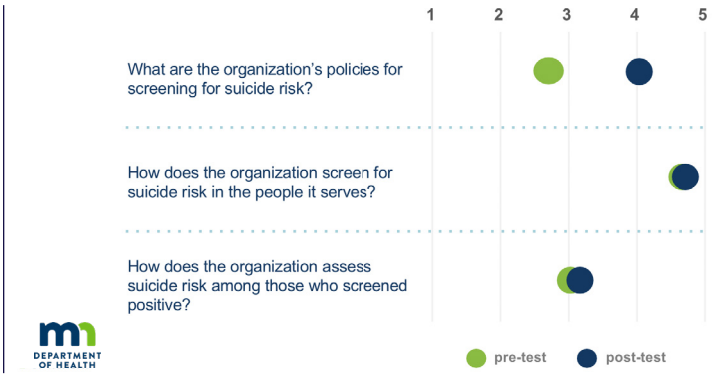
Training for non-clinical staff was a significant area of growth across this collaborative, as several of the organizations took advantage of training opportunities offered by MDH. More than one organization built in regular training expectations and one built online, on-demand training opportunities for staff.

Only one organization reported providing training for clinical staff. As indicated by the organizational self-study, all of the teams reported room for improvement in this area.



Element 3: Identify individuals with suicide risk via comprehensive screening and assessment

Screening practices improved across most organizations. While prior to this collaborative all organizations had screening embedded in protocols and electronic health record (EHR) systems in some settings, during the year-long collaborative they improved these workflows and also expanded them across additional settings and/or populations.



Screening

A deep dive to understand inpatient screening practices across four health systems indicated that all were using the Columbia-Suicide Severity Rating Scale (C-SSRS) for inpatient screening, and all are now screening universally across medical and mental health units. There is also variability in the use of the tool. For instance, two healthcare systems conduct screening for suicide risk starting at age 10, and two organizations screen starting at age 12.

Regarding re-screening of patients in the hospital setting who have scored at moderate to high risk, two systems re-screen with C-SSRS every shift or waking shift, while another organization re-screens twice a day using the C-SSRS. A fourth organization does not use C-SSRS to re-screen, instead having a protocol for conducting ongoing assessment each shift with specific interventions based on level of risk.

Assessment

Moving from screening to a comprehensive assessment was a goal of several organizations. For some, this meant doing the work to gain further behavioral health resources to support inpatient and/or primary care. One organization has implemented digital tools in both primary care and ED settings to aid in screening and assessment, providing support both to the patient and the provider team.

Prior to this collaborative all organizations reported they had implemented specific practices related to screening in some settings. Five organizations reported having practices in place specific to conducting assessment prior to the collaborative; afterwards all organizations had this in place based on answers to specific yes/no questions about components of care asked in the organizational self-study.

Organizational Self-Study Question Example

Do you have a written agency protocol specific to this component of suicide care?

Is this component embedded in your electronic health record or easily identifiable in your written documentation?

Do you provide staff training specific to this component of care?

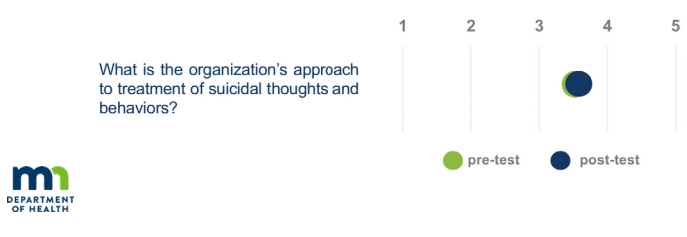
Element 4: Engage all individuals at-risk of suicide using a suicide care management plan

Based on self-study reports, some improvement was indicated in the development and documentation of suicide care management plans to be accessed across the organization, though this area still has room for improvement. In report-outs during the collaborative and in 1:1 calls, several organizations described the significant work done to set up EHRs to both capture and guide care management of people identified at risk.

Element 5: Treat suicidal thoughts and behaviors directly using evidence-based treatments

Little change was reported as to organizations' approach in using evidence-based treatments that directly target suicidal thoughts and behaviors. This self-reported score in part may reflect that these organizations had already chosen evidence-based screening and assessment tools during their prior work with ICSI, and have moved to safety planning instead of safety contracts. Clearly, however, these teams recognize room for further improvement.

Lethal means restriction remains a particular area of opportunity; all teams scored themselves fairly low in this area. One organization implemented positive changes in their approach to restricting lethal means during the collaborative, including written protocols.



Element 6: Transition individuals through care with warm hand-offs and supportive contacts

One of the biggest areas for improvement is in engaging hard-to-reach individuals or those who are at risk and don't keep follow-up appointments, although some progress is being made at some EDs to establish better follow-up for patients recently discharged.

Element 7: Improve policies and procedures through continuous quality improvement

An important contributor to implementation success at several organizations has been to establish a structure of workgroups to tap into various expertise and people needed to do the work. As one member stated, "while leadership is needed, it is not sufficient." These organizations established structures by which knowledge is shared, decisions are made, and more staff are engaged to support changes for continuous quality improvement.

In addition, several teams did significant work over time to embed suicide screening, assessment, safety planning, and/or care management plans into their EHR systems and workflows. One organization did a Kaizen process which identified needed changes and resourcing needed. Finally, one team has implemented a bonus incentive for clinicians to complete safety plans, making good progress toward their goal of completing them for 90% of patients who have suicidal ideation as their chief complaint.

Summary

Areas of further opportunity include measuring suicide deaths for those enrolled in care, and addressing lethal means reduction. All teams acknowledged room for improvement in involving suicide attempt and loss survivors in the design, implementation, and improvement of suicide care policies and activities. While some teams have made intersections with their suicide prevention work and health equity, others acknowledge this as a need.

The dedication of each of these teams to advance suicide prevention and intervention improvements during the constraints of a pandemic is notable. Significant changes were made at most organizations to improve screening, assessment and/or safety planning. Investments made in training non-clinical staff, building EHR processes and workflows, and creating quality improvement infrastructure by which to monitor progress and implement further changes all bode well for advancing further change in future.