

# Aiming for Zero: Zero Suicide at CNS Healthcare

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# The Zero Suicide Framework

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## Why Zero Suicide?

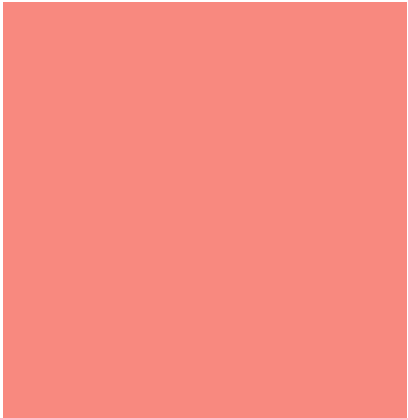
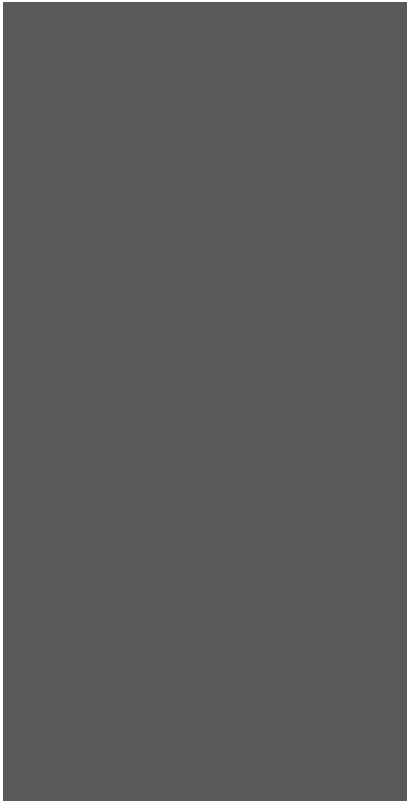
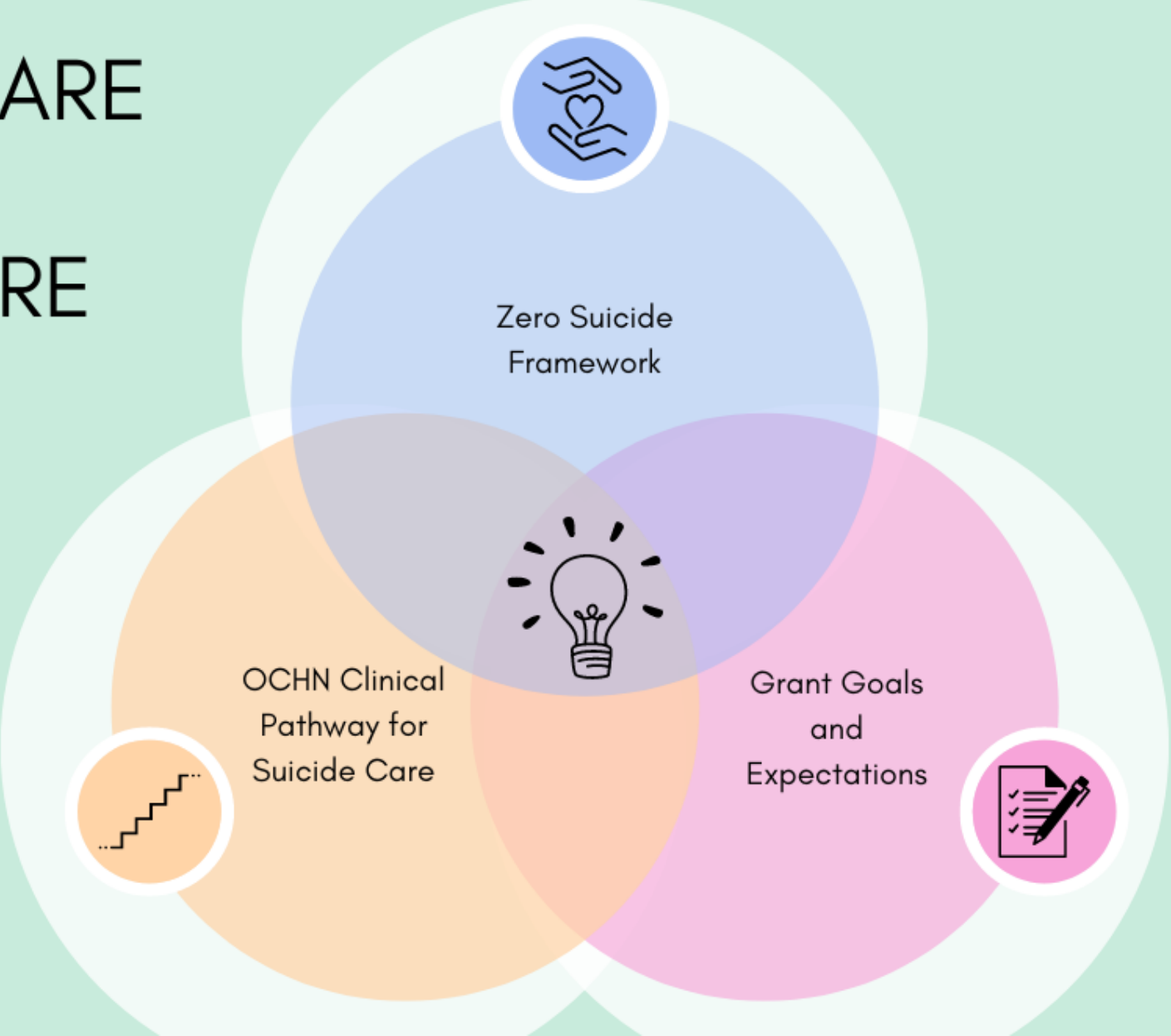
- The idea that suicide deaths for individuals under the care of health and behavioral health systems are preventable
- Presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.

## Evidence for Zero Suicide

- 95% of individuals were seen by a healthcare professional within a year before attempting suicide
- 64% of individuals were seen by a healthcare professional within a month before attempting suicide



# SUICIDE CARE AT CNS HEALTHCARE



# Lead: Structural Changes

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- Creation of Zero Suicide Steering Committee
  - Organizational Self Study
  - Workforce Survey
- Creation of Suicide Prevention Team
  - As a result of the grant
  - Mostly administrative in nature
- Implementation of staff and supervisor support structures to aid in implementation



# EHR Changes

Additional C-SSRS Tools added to system

Instituting the use of the C-SSRS Screener

Addition of Suicide Care Progress Note

Addition of the ability to track suicide attempts and deaths in Progress Notes

Enhancements to Hospital Progress note to document reason for hospitalization and offering of Suicide Care Services

Addition of Suicide Care chart banners

Changes to Crisis Plan to enhance documentation of the reduction of lethal means and offering of Suicide Care Services



# Train

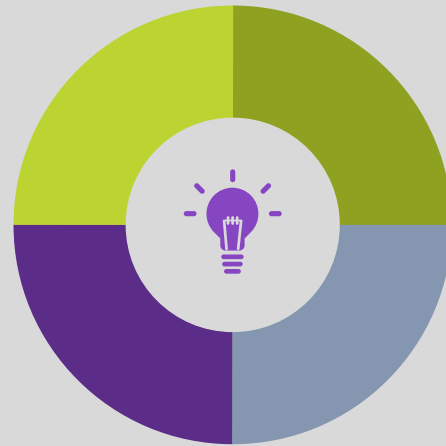
- Core Training
- Outside trainers
  - Therapists
  - Supervisors
- ASIST
  - ASIST T4T
- Specialized trainings
  - Safety planning
  - Lethal Means Reduction



# Identify, Engage, Treat: Components of Suicide Care at CNS

Universal  
Screening

Universal  
screenings



Safety  
planning and  
reduction of  
lethal means

Enhanced  
Clinical  
Supports

# SUICIDE CARE

## Low Risk

### Low Risk Suicide Care - Banner in Thor

- Update Crisis Plan
- Create Safety Plan
- Reduce Access to Lethal Means
- NOMS
- Specialist Approval
- Suicide Care Progress Note
- Review Safety Plan at each Meeting
- Recommend Therapy
- C-SSRS Screener every 90 Days

## Moderate & High Risk

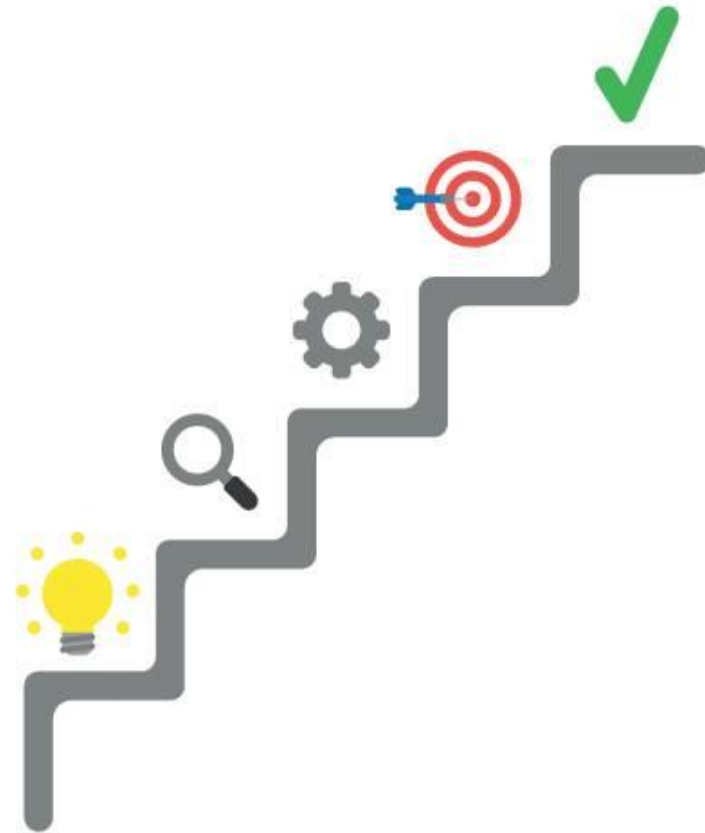
### Clinical Pathway - Banner in THOR

- Clinical Pathway Care Agreement
- Update Crisis Plan
- Create Safety Plan
- Reduce Access to Lethal Means
- NOMS
- Specialist Approval
- Weekly Therapy
- Suicide Care Progress Note
- Review Safety Plan at each Meeting
- C-SSRS Screener Review at each Contact
- Increased Engagement Protocol

FEATURES	NO RISK	LOW RISK	MODERATE/ HIGH RISK
Thor Chart Banner		<b>GREEN</b> Low Risk Banner	<b>RED</b> Clinical Pathway
Suicide Care Progress Note		✓	✓
Crisis Plan Review	✓	✓	✓
Safety Plan		✓	✓
Reduction of Lethal Means		✓	✓
NOMS	✓	✓	✓
C-SSRS Screener	At periodic reviews, or when risk is suspected	Every 90 Days, or when increased risk is suspected	Each contact, minimum weekly
Therapy	Referral if desired	Referral recommended	Required weekly
Clinical Pathway Agreement			✓
Enhanced Engagement Protocol			✓
Suicide Prevention Team Consultation	Available	Available	Available

# Transition

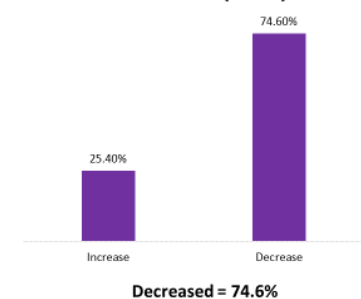
- Four weeks of low- to no-risk C-SSRS
- Clinical Case Conference process
- Ability to step up or down in level of suicide care



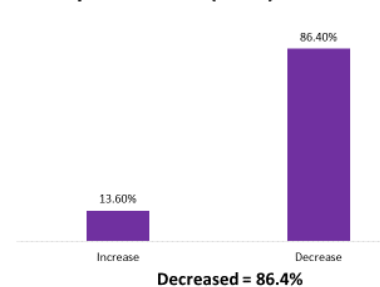
## Zero Suicide NOMS Data H1a-b

Clients with at least 2 assessments

### Considered Suicide (n=71)



### Attempted Suicide (n=22)

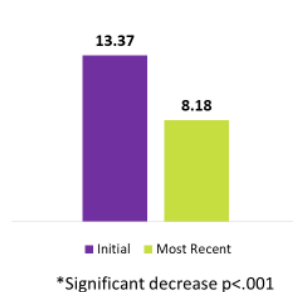


NOTE: Clients who had 0 for considered or attempted at T1 and T2 were removed

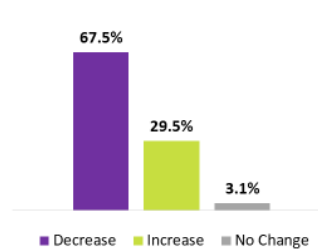
## Zero Suicide PHQ-9 Data (n=292)

Clients with at least 2 assessments

### Average PHQ-9 Scores at Initial and Most Recent\*



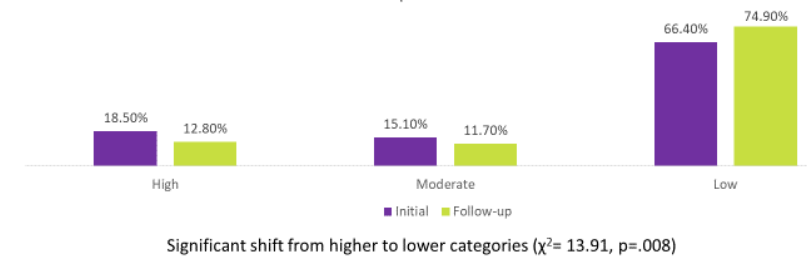
### Change in PHQ-9 Scores From Initial to Most Recent



## CSSRS Data (n=298)

Clients with at least 2 assessments 1 month apart

Clients with at least 2 assessments 1 month apart



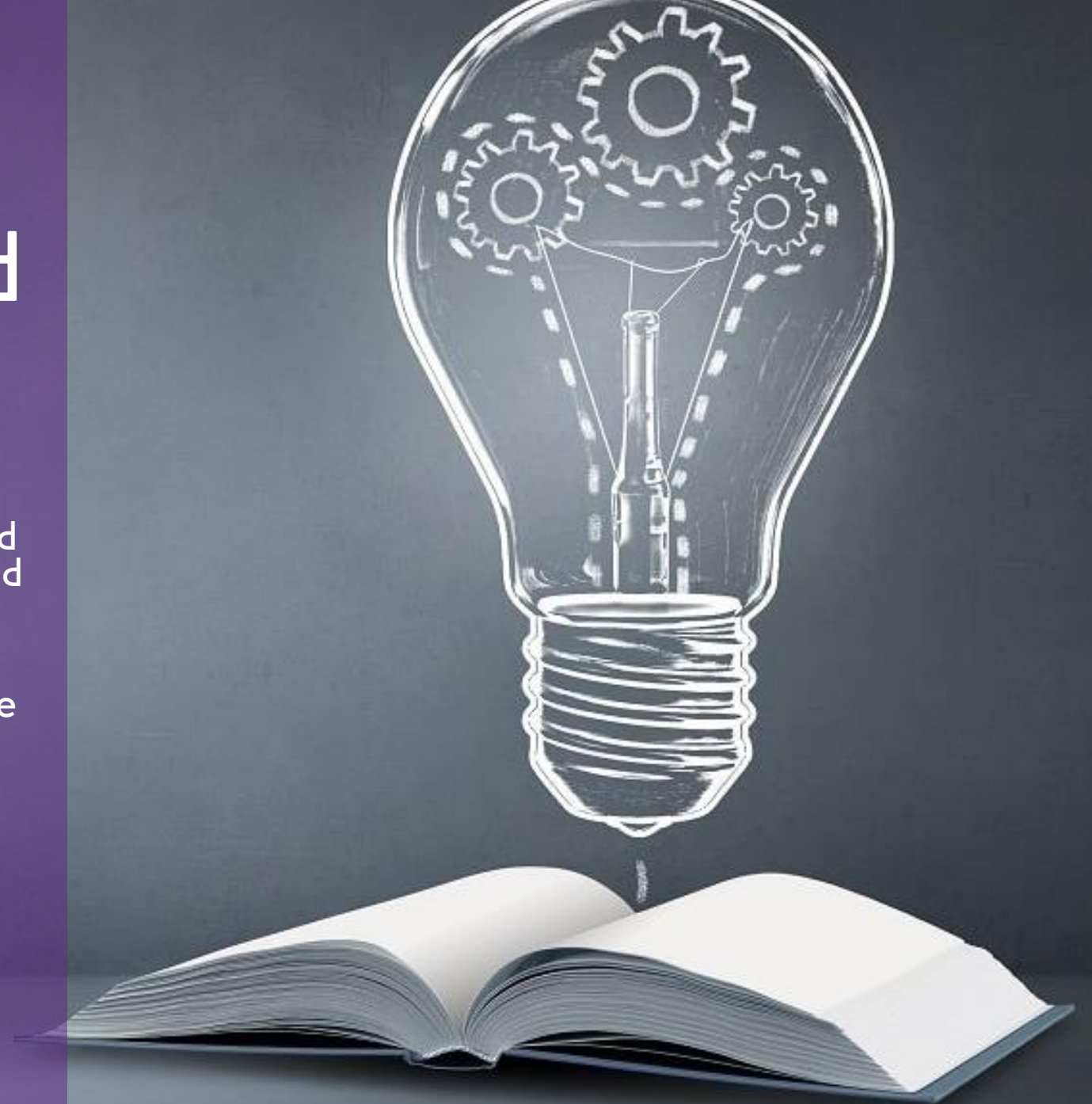
N=156 cases where the score was 'High' on the initial. 26.3% were found on the Pathway (n=41)

# Improve



# Barriers & Lessons Learned

- Did you know there's a staffing shortage??
- Difference between responding to and treating suicidal thoughts, feelings, and behaviors
- The historical “system” response to suicidality is different than true suicide intervention and prevention
- It is important for staff to understand suicidality – it's not just another process
- Shift viewpoint from “this is an extra program” to “this is a more effective way of saving lives”



Any Questions

