Oregon Zero Suicide in Health Systems Request for Proposals for Zero Suicide Initiative Implementation Funds

Track 1: Zero Suicide Initiative Implementation Support

Deadline for applications: August 13, 2023

OVERVIEW

The Association of Community Mental Health Programs (AOCMHP), with funding from the Oregon Health Authority, will provide up to ten 1-year mini-grants, ranging from $15,000 to $35,000 to healthcare organizations or care coordination partners to support one of the following efforts:

1) **Zero Suicide Initiative Implementation Support:** Support implementation of the Zero Suicide framework in Oregon health systems to reduce suicide risk for adults 25 and older. Health systems must have established Zero Suicide efforts in place.
2) **Safer Suicide Care Initiatives for Priority Communities:** Support population-specific safer suicide care initiatives in Oregon health systems, care coordination partners, care facilities or community-based organizations focused for three priority communities: (1) older adults (65 and older), (2) adults with serious mental illness, and (3) veterans and individuals that have served in the military.

Mini-grants funds in the total amount of $270,000 are available through OHA Grant #SM083398 from the US Substance Abuse and Mental Health Administration's Zero Suicide in Health Systems grant. Priority will be given to proposals that include equity and lived experience considerations to inform project implementation. OHA's SAMHSA-funded Zero Suicide Initiative targets the following priority communities: (1) older adults (65 and older), (2) adults with serious mental illness, and (3) veterans and individuals who have served in the military. There are two tracks for the application:

1. **Zero Suicide Initiative Implementation Support track**: Applicant organizations must operate in the health or behavioral healthcare field and meet at least one of the following additional eligibility requirements: (1) past attendance at a Zero Suicide Academy or (2) demonstrated adoption of and ongoing commitment to Zero Suicide implementation. Successful applications must include a plan and timeline for implementing specific strategies that further integration of the Zero Suicide framework within their health system. Strategies may include developing policies and practices to further Zero Suicide efforts, supporting staff training, facilitating strategic planning of Zero Suicide implementation, implementing a quality improvement project that supports Zero Suicide efforts, or upgrading electronic health records to enhance tracking of Zero Suicide metrics.
2. **Safer Suicide Care Initiatives in Priority Communities** track, applicant organizations can be a health or behavioral healthcare organization or organization that provides direct services to support the health of Oregonians. Proposals must be focused on at least one of the priority communities: (1) older adults (65 and older), (2) adults with serious mental illness, and (3) veterans and individuals that have served in the military. Successful applications must include a plan and timeline that demonstrate commitment to providing safer suicide care for priority communities.

The funding period is August 29, 2023 – August 28, 2024. This document provides an overview and the application for the **Zero Suicide Initiative Implementation Support** track.

A. BACKGROUND/OVERVIEW OF FUNDING:

The Zero Suicide Initiative presents an aspirational challenge and practical framework for health system-wide transformation toward safer suicide care for systems dedicated to improving patient safety. The Zero Suicide model operationalizes the core components of safer suicide care that enables health systems to identify, engage, treat, refer and ensure continuity of care through a quality improvement lens for individuals at risk of suicide, experiencing thoughts of suicide, or have survived a suicide attempt.

Oregon Health Authority (OHA) Public Health Division's Injury and Violence Prevention Program received SAMHSA Zero Suicide in Health Systems grant funding through August 29, 2025. AOCMHP is supporting OHA in implementation of grant activities and will administer funding to selected applicants. OHA will oversee grant implementation.

Purpose: The purpose of the **Zero Suicide Initiatives Implementation Support** track is to support further implementation of Zero Suicide in health systems with established initiatives aimed at reducing suicide risk for adults 25 and older. Successful applicant organizations must operate in the health or behavioral healthcare field and meet at least one of the following additional eligibility requirements: (1) past attendance at a Zero Suicide Academy or (2) demonstrated adoption of and ongoing commitment to Zero Suicide implementation.

Allowable Activities: Activities that can be funded by this grant include:

- Staff training and organizational support to create a competent, confident and caring workforce,
- Strategic planning of Zero Suicide implementation through dedicated FTE or contract,
- Quality improvement projects that support Zero Suicide efforts,
- Electronic health record upgrades that enhance tracking of measures included in the Zero Suicide Metrics worksheet,
- Other strategies that support Zero Suicide efforts.

Required Components: Applicants are expected to address equity considerations and involvement of individuals with lived experience in proposed projects, and participate in evaluation activities documenting progress and identifying best practices to share with other organizations implementing Zero Suicide.

OHA has a goal to eliminate health inequities in Oregon by 2030[1] through ongoing collaboration to address the equitable distribution and redistribution of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices. Engagement of communities who services are being design for is essential to ensuring services reach intended individuals. This may be done by involving individuals from those communities in service design or forming

[1] OHA health equity definition: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including Tribal governments to address: The equitable distribution or redistribution of resources and power; and Recognizing, reconciling and rectifying historical and contemporary injustices.

partnerships with community organizations supporting the community of focus to help identify individuals for services. Individuals with lived experience as a consumer of health services or related to suicide are an essential component to developing, implementing and evaluation efforts. As part of the development of the Oregon Adult Suicide Intervention and Prevention Plan, a workgroup developed lived experience values to be considered in all suicide prevention, intervention and prevention work (refer to Appendix A). Applicants are expected to address how individuals with lived experience will be involved in their proposed project.

The Zero Suicide Institute also emphasizes the essential role that individuals with lived experience have in developing, implementing and evaluation efforts[2]. Amplifying the voices of those with lived experience allows organizations to better understand the impact of their services and create a system of care in which individuals feel respected, heard, and safe.

B. ELIGIBILITY AND FUNDS AVAILABLE:

- Up to 10 grants between $15,000 - $35,000 each will be funded from August 29, 2023 – August 28, 2024. Total funds available are $270,000
- Funders will aim to fund projects in a variety of geographic areas and will prioritize proposals that intentionally address equity considerations and involvement from individuals with lived experience.
- Entities that have been awarded their own SAMHSA Zero Suicide in Health Systems Grant or are currently receiving OHA SAMHSA Zero Suicide in Health System Grant funds are not eligible.
- Grants must support safer suicide care for adults aged 25 and older based on SAMHSA Zero Suicide in Health System Grant requirements.

C. GRANT REQUIREMENTS:

1. **Work plan and timeline:** Applicants have flexibility in how they propose to use the funds to support Zero Suicide implementation. Activities must fall into one or more of the following categories:

   A. **Staff training and organizational support to create a competent, confident and caring workforce.** Applicants must propose a plan and timeline to train staff and specify which staff will be trained (template provided). Applicants should refer to the Zero Suicide Suicide Care Training Options resource when selecting specific training options. If applying the funds to other trainings, applicants must cite the evidence base or best practices that demonstrates their effectiveness. Trainings that are tailored to support a specific workforce or community will also be considered with an accompanying justification. Funds may also be used to develop a Zero Suicide introduction in new employee orientations or to provide staff training on organizational policies and procedures related to Zero Suicide implementation. Applicants must describe how these trainings correspond with the **TRAIN**

[2] The Zero Suicide Institute: Lead: Lived Experience Webpage.

element of Zero Suicide**.** Applicants are encouraged to focus on trainings that would meet the needs and existing capacity of their staff and/or volunteers in working with the populations they serve. Applicants must include how they will support staff in implementing training learning objectives. Proposals that only fund training without follow-up support for staff to effectively implement training skills will not be funded. Applicants should explain the strategies they will put in place (e.g.: learning collaborative, supervision, role play sessions, building protocols based on training skill acquisition into documentation, etc.) to support staff in practicing and implementing their new skills following training.

B. **Strategic planning of Zero Suicide implementation through FTE or contract.** Strategic planning efforts may include (1) policy and/or procedure development or (2) Zero Suicide Implementation Team strategic planning activities. Applicants must reference the specific Zero Suicide element the work will relate to, describe how funds would support Zero Suicide implementation, and include a brief implementation plan and timeline (template provided).

C. **Quality improvement project that supports Zero Suicide efforts.** The development and implementation of a quality improvement project that supports Zero Suicide efforts may include: (1) enhanced data collection to track adherence to Zero Suicide activities or patient or staff safety initiatives. Applicants must reference the specific Zero Suicide element that work will relate to, describe how funds would support Zero Suicide implementation, and include a brief implementation plan and timeline (template provided). For more information on Zero Suicide metrics, refer to the Oregon Zero Suicide Implementation Assessment Tool (Appendix B) and Zero Suicide Metrics worksheet.

D. **Electronic health record (EHR) upgrades that enhance tracking of measures included in the Zero Suicide data elements worksheet.** EHR updates, or work supporting upgrades, are eligible for funds under this grant opportunity. Applicants must reference the specific Zero Suicide element that work will relate to, describe how funds would support Zero Suicide implementation, and include a brief implementation plan and timeline (template providers)

E. **Other strategies that support Zero Suicide efforts**. Applicants are encouraged to propose additional projects that will further Zero Suicide efforts. Applicants must reference the specific Zero Suicide element the work will relate to, describe how the use of funds would support Zero Suicide implementation, and include an implementation plan and timeline (template provided).

2. **Collaboration**: Grantees are expected to participate in an initial one-hour grant award call and a one-hour grant closing call with OHA and the Portland State University project evaluation team to be trained on reporting tools, discuss progress and needs, and share best practices and lessons learned.

3. **Reporting:**

   A. **Training activities**: Grantees using the funds for training must report the (1) training date, (2) topic, and (3) number of clinicians/healthcare professionals and non-clinicians trained for each grant-funded training to PSU via web survey. They must also provide participants with a link to a standardized evaluation web survey from the PSU Zero Suicide evaluators or collect an evaluation of the training and submit a summary for each training to PSU. Summaries of PSU training evaluations will be provided to grant sites and shared with OHA for planning purposes.

   B. **A final summary** of grant activities and outcomes will be required 30 days following the end of the grant period. A reporting form or specific reporting guidelines will be provided for this purpose.

4. **Evaluation:** The Human Services Implementation Lab (I-Lab) at Portland State University (PSU) is conducting an evaluation of the impact of OHA's SAMHSA Zero Suicide in Health Systems grant. At the end of this project, grantees implementing Zero Suicide activities will be asked to complete the Oregon Zero Suicide Implementation Assessment Tool (See Appendix B) to gauge Zero Suicide implementation progress. An individuated implementation outcome report will be provided and, if requested, can include previous assessment data to show changes in implementation efforts. A de-identified cross-site report will be created that demonstrates the progress made across all participating sites. The cross-site report will be shared with OHA and SAMHSA, the federal agency funding OHA's Zero Suicide efforts. Applicant grant funds may be used to supplement the organizational self-assessment with an optional external Zero Suicide Assessment conducted by PSU's I-Lab. The external assessment would include a customized all-staff survey, consumer input, key informant interviews, and a document review. For information on the design end pricing of these external assessment components, visit the Human Services Implementation Lab website and refer to the Zero Suicide Fee Schedule.

5. **Funding Restrictions:**

   Grant funds, per SAMHSA Standard Funding Restrictions, may not be used to:

   - Purchase food or beverages.

   - Directly or indirectly, purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

- Pay for promotional items including, but not limited to, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

- Pay for the purchase or construction of any building or structure to house any part of the program.

- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision.

- Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

- Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services.

- Purchase sterile needles or syringes for the hypodermic injection of any illegal drug.

- Pay for pharmaceuticals for HIV antiretroviral therapy, sexually transmitted diseases (STD)/sexually transmitted illnesses (STI), tuberculosis (TB), and hepatitis B and C, or for psychotropic drugs.

D. <u>TIMING</u>:

- Information/application posted: July 11, 2023
- Deadline for applications: August 13, 2023 at 11:59pm
- Notice of Award: August 25, 2023
- Project start date: August 29, 2023
- Project end date: August 28, 2024
- Final report due: September 30, 2024

E. <u>PAYMENT PROCESS</u>: Grant funds will be released to the designated project/fiscal lead entity by AOCMHP when the project plan and budget have been approved.

F. <u>PROPOSAL CRITERIA TO BE ADDRESSED BY APPLICANTS</u>:

1. Organization or partnership (Limit: 1 page)

a. Identify the applicant organization(s), number of staff, and number of patients or clients served in 2022. Provide the name and contact information for the project lead.

b. Identify the existing Zero Suicide Implementation Team members and how often the group meets. Identify individuals with lived experience involved in the organization's Zero Suicide Implementation Team and how individuals with lived experience are involved in the organization's Zero Suicide efforts.

c. Describe the status of Zero Suicide implementation efforts since applying or attending the Zero Suicide Academy and current leadership support for Zero Suicide.

2. **Project Implementation (Limit: 2 pages)**
   a. Identify specific objectives to be accomplished during the 12-month grant period. Describe how the applicant will utilize the funds to move Zero Suicide efforts forward. Indicate how clients/patients will benefit from the project(s). If training staff, indicate how many staff the organization expects to train, timeline for this to occur, what specific training will be providing and who will provide training. If training staff, indicate how the organization will support staff in training skills implementation. If non-training projects are proposed, indicate how many staff will be impacted.
   b. Describe how individuals with lived experience will be involved in Zero Suicide implementation efforts.
   c. Indicate who will be responsible for coordinating this project, participating with OHA and PSU as part of grant calls and collecting required evaluation measures.
   d. Describe how the project addresses health inequities.
   e. Describe how progress toward grant objectives will be measured.
   f. Briefly describe how Zero Suicide implementation will be sustained beyond the funding period.

3. **Workplan (Limit 2 pages)**. Provide a workplan that includes the timing for activities between August 29, 2023 – August 28, 2024. Organizations may use the attached template or a workplan format of their own choosing.

4. **Budget (Limit 1 page)**. Provide a brief budget outlining proposed use of $15,000 - $35,000. Organizations may use the attached template or a budget of their own choosing.
   - Note: Indirect costs are capped at 15%. If a higher indirect is required, provide an explanation for the higher indirect.

5. **Letters of Commitment (No page limit)**. The lead applicant must provide a letter of commitment to participate in the project signed by organizational leadership.

G. APPLICATION DEADLINE AND LOGISTICS

Applications are due by 11:59pm PST on August 13, 2023. Applications and supporting materials should be submitted electronically to Maria Gdontakis Pos at AOCMHP (mpos@aocmhp.org).

Content questions may be addressed to: Meghan Crane, OHA at meghan.crane@oha.oregon.gov.

H. EVALUATION PROCESS AND CRITERIA

To be considered for funding, each proposal must address:

- At least one element of Zero Suicide
- A clearly defined activity related to Zero Suicide implementation.
- A work plan that can be achieved in the funding period.

Applications will be reviewed by at least three reviewers who will consider the following selection criteria.

a. **Applicant interest and capacity.** (20 pts) Has the organization sent staff to a previous Zero Suicide Academy and/or clearly demonstrated commitment to the Zero Suicide Initiative? Does the proposal clearly indicate current movement to implement Zero Suicide and leadership support? Does the organization demonstrate that individuals with lived experience are involved in their Zero Suicide efforts? Does the organization(s) show that they have capacity to manage grant funds? Is a letter of commitment from organization leadership included?

b. **Project plan**. (40 pts) Does the applicant identify strategies that support Zero Suicide implementation? Does the applicant refer to the Zero Suicide Toolkit and seven elements to support proposed project(s)? Does the project intentionally address equity considerations? Does the applicant indicate how staff and patients/clients will benefit from the proposed project(s)?

c. **Workplan and coordination**. (30 pts) Does the proposal provide a clear and feasible timeline for accomplishing the proposed work? Is project coordination clear? Does the workplan include meaningful involvement of individuals with lived experience? Does the workplan describe how suicide-related metrics will be gathered and reported? Does the workplan include steps for gathering data regarding the level of Zero Suicide implementation and progress toward their proposed objectives?

d. **Budget**. (10 pts) Does the majority of funding support Zero Suicide implementation? Does the budget seem reasonable in light of the proposed project?

APPENDIX A. Adult Suicide Prevention and Intervention Plan Lived Experience Values/Framework

Types of Lived Experience with Suicide

1. Lived Self Experience
    a) Including first time-, episodic- and/or chronic- thoughts, urges, actions.
    b) This includes people with lived experience regardless of whether or not someone has received treatment or a formal diagnosis.

2. Lived Supporter Experience
    a) Formal / informal support for someone with lived self-experience or lived loss.
    b) These supports could be trained professionals, trained gatekeepers, unpaid helpers, or voluntary empathic care.

3. Lived Loss Survivor Experience
    a) Someone who has a personal loss of someone they know to suicide.
    b) Someone who has lost someone to suicide in a professional capacity.
    c) Someone who has been exposed to a suicide loss in any capacity, such as the loss of a loved celebrity or public figure.

For all of these identities, we acknowledge the entire spectrum of experiences and know that not everyone will fit into the above categories.

Values

1. Nothing about us without us.
2. Self-determination. We have autonomy and choice around our treatment. For example, I am able to decide who I choose to see and am receiving the treatment I selected.
3. We are respected as the expert in our life; we're believed when we share our story. For example, no gaslighting. No condescension.
4. Right to confidentiality. Our information is only shared with who we choose, how we choose and when we choose to share.
5. We have the right to access and preserve our charts and notes. We want to be able to review and annotate our chart to ensure accuracy.
6. We have the right receive support and treatment without judgement. People are seen as individuals and not their diagnosis. I may have schizophrenia but I'm not "a schizophrenic". I'm many things and although I may be impacted by my diagnosis, I'm not my diagnosis.

7. Our identities are respected, and services are individually and culturally responsive.
8. Services should be accessible and equitable to all. For example, materials should be offered in different formats and languages, and in plain language. When technical terms must be used, a glossary should be included. We need physical access to services for those with physical, cognitive, and other disabilities.
9. Providers and programs are trauma informed, trauma free, and trauma responsive. Safe spaces should be created for people to share their experiences and truth.
10. The harm-reduction approach should be widely implemented among providers. We should not be excluded from treatment or services due to any substance use concerns. We should not be excluded from services for “not getting better” on “your timeline”.

Appendix B: Oregon Health Authority/Portland State University

Oregon Zero Suicide Implementation Assessment Tool (version 2.1), an adaptation of EDC's Zero Suicide Organizational Self-Study

Element #1: Lead

Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

Element #2: Train

Develop a competent, confident and caring workforce.

Element #3: Identify

Systematically identify and assess suicide risk among people receiving care.

Element #4: Engage

Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet individual needs.

Element #5: Treat

Use effective, evidence-based treatments that directly target suicidality.

Element #6: Transition

Provide continuous contact and support, especially after acute care.

Element #7: Improve

Apply a data-driven quality improvement approach to inform system changes leading to better care and improved outcomes for individuals at risk.

Suggested Citation:
Cellarius, K., Kuhn, S., Tuttle, A., Crane, M., Murray, G., Taylor Parker, C. , Lisborg, K. (2023) Oregon Zero Suicide Implementation Assessment Tool (v.2.1), an adaptation of EDC's Zero Suicide Organizational Self-Study. Portland, OR: Portland State University.

Background:

This 2023 update to the 2018 Zero Suicide implementation assessment tool and the accompanying web survey is a collaboration of Portland State University's Human Services Implementation Lab, the Oregon Health Authority, the Zero Suicide Institute and other contributors. The assessment was adapted from the Education Development Center's Zero Suicide resources available at http://zerosuicide.org/. Content is drawn mainly from:

- The **General and Inpatient Self-Studies**: Questionnaires about the extent to which each component of the Zero Suicide approach is in place at a single organization. Zero Suicide recommends completing this self-study at the start of an organization's Zero Suicide initiative, then every 12 months after that as a measure of fidelity to the model. **The self-study questions serve as the basis for this Oregon Zero Suicide Implementation Assessment and have been reformulated as indicators**. The response options (or anchors) for each question are included in the grid to define the level of implementation for each indicator.
- The **Data Elements Worksheet**: A list of primary and supplemental measures recommended for behavioral health care organizations to strive for to maintain fidelity to a comprehensive suicide care model. The supplemental measures are clinically significant but may be much harder to measure than the primary measures. Zero Suicide recommends reviewing these data elements every three months in order to determine areas for improvement. **Starting with element #3 (Identify) of this implementation assessment, these data points are requested for each relevant indicator as documentation for the rank awarded. Additional data points for indicators added to version 2 of this adaptation were developed by PSU.**

OHA is using this implementation assessment to track change over time related to suicide prevention efforts among organizations participating in Zero Suicide Academies sponsored by OHA and the subsequent Zero Suicide Community of Practice Conference Calls. Funding is provided in part by the US Substance Abuse Mental Health Services Administration (SAMHSA).

For more information on:

- **Zero Suicide**, visit http://zerosuicide.org/
- **OHA's Zero Suicide Initiative**, contact Megan Crane, OHA Zero Suicide Coordinator at Meghan.Crane@dhsoha.state.or.us
- **The study being conducted using this instrument**, contact Karen Cellarius, Director, Human Services Implementation Lab (https://hsimplementationlab.org/) and Senior Research Associate, Portland State University Regional Research Institute for Human Services at cellark@pdx.edu

Zero Suicide (ZS) Implementation Indicators by Element

Self-Assessment Instructions: Use the detailed definitions beginning on page 3 to rate the implementation level of Zero Suicide. If every component of a defined rating is not in place, the score has not yet been achieved. Document the reason for the score in the space provided. Include metrics, if available. Transfer the scores to the table below to calculate the overall implementation score for your agency or department. Repeat the process at least annually to track change in implementation level over time.

Scale:

1=Organization has not yet demonstrated awareness for the need for this component of Zero Suicide.

2=Organization has demonstrated awareness, but work on this component has not yet begun

3=Organization is actively working to implement component

4=Component is in place, but it is not yet sustainable or monitored

5=Component is sustainably in place, monitoring for continuous quality improvement occurs regularly and includes input from people with lived experience.

INDICATOR	SCORE
Element #1: Lead Mean→	
Commitment to Zero Suicide (NEW)	
Commitment to DEI (NEW)	
Staff readiness to implement ZS (NEW)	
Messaging to staff related to ZS adoption (NEW)	
Written Protocols	
Suicide Care is Documented	
Availability of Trainings	
Dedicated Staff Time for Zero Suicide	
Survivor Involvement in Planning and Processes	
Just culture/philosophy of care (NEW)	
Workforce wellness (NEW)	
Element #2: Train Mean→	
Assessment of Workforce Confidence	
Trainings for Non-Clinical Staff	
Trainings for Clinical Staff	
Element #3: Identify Mean→	
Screening for Suicide Risk	
Screening Tools Used	
Suicide Risk Assessment	

INDICATOR	SCORE
Element #4: Engage Mean→	
Care for Individuals At-Risk for Suicide	
Collaborative Safety Planning	
Lethal Means Counseling	
Postvention for staff and individuals in care (NEW)	
Postvention for affected community members (NEW)	
Element #5: Treat Mean→	
Access to Suicide-specific Treatment	
Safer Inpatient Environments (NEW)	
Element #6: Transition Mean→	
Engaging Hard to Reach Individuals	
Follow-up after Transitions in Care	
Element #7 Improve Mean→	
Analysis of Suicide Deaths	
Tracking Suicide Deaths	
Analysis of Suicide Attempts (NEW)	
Tracking Suicide Attempts (NEW)	
Appropriateness of Suicide Safer Care (NEW)	
Continuous Quality Improvement (CQI)	

Element #1: Lead

Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

Commitment to Zero Suicide (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
How does leadership demonstrate their commitment to the Zero Suicide framework within the organization?		Leadership has not yet demonstrated awareness of the need to implement ZS.	Leadership is aware of the value of implementing ZS, but has not yet developed a plan to address it.	Organization has developed a plan toward implementing ZS.	ZS implementation strategies are established in strategic plan. ZS is an ongoing effort, but funding and leadership support are limited. If key staff leave, the initiative may not continue.	Organization has infrastructure to sustain ZS (e.g., work group, champion, etc.). Organization supports ZS implementation through active planning and ongoing budget allocation. Leadership implements changes as a high priority.
Comment or justification for score:						

Commitment to DEI (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
How does leadership demonstrate their commitment to diversity, equity and inclusion (DEI) within the organization?		Leadership has not yet demonstrated awareness that diversity, equity and inclusion (DEI) are key components of suicide prevention	Leadership is aware that inclusion goes beyond inclusion of people with lived experience of suicide to inclusion of people with lived experience of the communities being served. Diversity and equity are also valued for their positive impact on mental health and reduced suicide risk. However, a plan to address DEI has not yet been developed.	Leadership has developed a plan for building DEI within the organization and the communities being served. The plan is informed by input from members of those communities, including organizational staff, service users, and individuals with lived experience.	DEI building strategies are established in strategic plan. Staff and individuals served approve of DEI strategies. DEI is an ongoing effort, but funding and leadership support are limited. If key staff leave, the initiative may not continue.	Organization has infrastructure to sustain DEI (e.g., work group, champion, etc.). Organization supports DEI building strategies through active planning and ongoing budget allocation. Efforts continue to be assessed with input from staff and individuals from the communities being served.
		Comment or justification for score: **Suggested metrics:** Method for assessing implementation of DEI principles: _____. Data that is tracked: ☐ Lived experience. READ: ☐Race, ☐Ethnicity, ☐Language, ☐Disability SOGIE: ☐ Sexual Orientation, ☐ Sender Identity, and ☐ Gender Expression.				

Staff readiness to implement ZS (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
Are staff committed to implementing ZS and feel confident the organization can support staff and handle challenges that might arise related to ZS?		Leadership has not yet demonstrated awareness of the need to assess staff buy-in for ZS.	Leadership is aware of the need to assess and promote staff buy-in for ZS, but work has not yet begun.	Leadership is assessing level of staff readiness by listening and responding to their concerns, but staff buy-in is limited.	Staff are committed to implementing ZS and feel confident the organization can support staff and handle challenges that might arise related to ZS, but commitment may wain if process becomes difficult.	Staff are committed to implementing ZS, feedback loops are in place for staff to express concerns, and the assessment of confidence is ongoing.
Comment or justification for score:						

Messaging to staff related to ZS adoption (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
How are Zero Suicide policies and practice communicated to staff?		Organization has not yet demonstrated awareness of the need for consistent messaging around organization-wide implementation of Zero Suicide.	Organization is aware of value of consistent messaging, but has not yet developed a plan to do so.	A comprehensive communication and messaging plan has been developed and some messaging is occurring. Messaging is infrequent. Less than 50% of staff are aware of the initiative.	A comprehensive communication and messaging plan is in place that engages communications from multiple levels of leadership to reach all staff on a consistent basis in a multitude of communication platforms.	Organization-wide communication around ZS occurs at least monthly and in multiple formats. Staff awareness and buy-in of ZS is assessed. The communication plan is reviewed at least annually.
Comment or justification for score: Suggested metric: Tools used for messaging: ☐ Monthly CEO letter, ☐ Quarterly safety newsletter, ☐ All staff or "town council" meetings on ZS efforts, ☐ Standing agenda items on regularly-meeting committees, ☐ Method to report out ZS data on a consistent basis, ☐ Engage buy-in and follow-through with ZS activities (such as the WFS, etc.)						

Written Protocols	Rating	1	2	3	4	5
Does the organization have written **protocols** for specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans? How are staff made aware of these protocols?		The organization has not yet demonstrated awareness for the need for all staff to be aware of the protocols for all five components of suicide care.	The organization has demonstrated awareness of the need for all staff to be aware of suicide specific protocols, but a plan for building awareness for all five components has not yet been developed.	The organization has developed a plan for building awareness for the protocols for all five components of suicide care and awareness building activities have begun for all staff.	All staff have been made aware of the written protocols for all five components of suicide care.	Leadership engages staff annually in suicide care protocols through education and evaluation of their knowledge of the written protocols. Awareness building processes are reviewed and modified annually and as needed.
Comment or justification for score:						

Suicide Care is Documented	Rating	1	2	3	4	5
Are specific components of suicide care embedded in the organization's electronic health record or easily identifiable in written documentation (if no EHR is available), including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans?		The organization has not yet demonstrated awareness for the need to embed all five components of suicide care in the organization's EHR or written documentation.	The organization has demonstrated awareness of the need to embed all five components of suicide care in the organization's EHR or written documentation, but they are not currently active data fields.	The organization has developed a plan to embed all five components of in the organization's EHR or written documentation, but not all components are in place yet. The plan includes regular monitoring.	All five components are embedded into the EHR or written documentation, but the monitoring plan has not yet been implemented.	All five components of suicide care are embedded into the EHR or written documentation, they are required or routinely documented by staff, and regular monitoring occurs. The monitoring plan includes continuous quality improvement.
Comment or justification for score:						

Availability of Trainings	Rating	1	2	3	4	5
Is training provided on specific components of suicide care, including (1) screening, (2) assessment, (3) lethal means safety, (4) safety planning, and (5) suicide care management plans?		The organization has not yet demonstrated awareness for the need to provide training on all five components of suicide care.	The organization has demonstrated awareness of the need to provide training on all five components of suicide care but a training plan has not yet been developed.	The organization has developed a plan to provide trainings on all five components of suicide care, but all trainings are not yet available.	The organization provides training on all five components of suicide care and has conducted at least one training on at least 4 of the 5 components. At least 50% of admin and direct service staff have been trained. A training evaluation plan has been developed.	The organization regularly provides training on all five components of suicide care and at least 80% of administrative and direct service staff have been trained. A training evaluation plan is used to monitor trainings for continuous quality improvement.
Comment or justification for score: *Metric: Percent of current administrative and direct service staff who have been trained.*						

Dedicated staff time for Zero Suicide	Rating	1	2	3	4	5
What type of formal commitment has leadership made through staffing to reduce suicide and provide safer suicide care?		The organization has not yet demonstrated awareness for the need for a formal commitment to dedicate staff to build and manage suicide care processes.	The organization has demonstrated awareness of the need for a formal commitment to dedicate staff to build and manage suicide care processes, but has not yet dedicated staff who are responsible for developing suicide-related processes and care expectations.	The organization has assembled an implementation team that meets on an as-needed basis to discuss suicide care. The team has authority to identify and recommend changes to suicide care practices.	The organization has a formal Zero Suicide implementation team that meets regularly and is multidisciplinary. The team is responsible for developing guidelines and sharing with staff. Staff members serve on the team for terms of one to two years. Inclusion of people with lived experience in planning occurs when practicable.	Implementation efforts are built into other initiatives related to quality improvement, risk management and individual safety. ZS processes are modified as needed based on data review and staff input. Lived experience is included in ZS implementation.
Comment or justification for score:						

Survivor Involvement in Planning and Processes	Rating	1	2	3	4	5
What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities?		Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization.	Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports.	Suicide attempt or loss survivors are specifically and formally included in the organization's general approach to suicide care, but involvement is limited to one specific activity, such as leading a support group or staffing a crisis hotline. Survivors informally provide input into the organization's suicide care policies.	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.	Suicide attempt and loss survivors participate in a variety of suicide prevention activities within the organization, such as sitting on decision-making teams or boards, participating in policy decisions, assisting with employee hiring and training, and participating in evaluation and quality improvement.
Comment or justification for score:						

Just Culture/ Philosophy of Care (NEW)	Rating	1	2	3	4	5
To what degree does the organization operate in a just culture approach to safety?		Organization has not yet demonstrated awareness that holding individual staff accountable for errors and mishaps impedes system change and error prevention.	Organization is aware of the benefit of a just culture, but work towards building just culture has not yet begun. Staff continue to be nervous around personal blame for addressing suicide risk.	Culture change is underway through building awareness and embedding just culture principles into the policies, practices and processes of daily work. Staff are increasingly aware that mistakes are generally a product of faulty systems, rather than solely brought about by those directly involved.	After an incident, staff ask "What went wrong?", rather than "Who is to blame?" Staff feel empowered to be a part of change-making and error reduction, and are confident they will receive organizational support in the wake of a suicide attempt or death.	All of the above, plus critical incidents are reviewed as they occur with an eye toward "What went wrong?" and practice and policy change are made as a result. Root cause analysis and cumulative fatality review data are also reviewed at least annually, and system changes are made as a result.
Comment or justification for score:						

Workforce Wellness (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
To what degree is agency workforce wellness (1) systematically addressed, (2) inclusive, (3) used by staff, (4) addressing the root causes of burnout, and (5) positively received by staff? Key components include: (1) Organization-Wide Wellness Team, (2) Person-Centered Wellness Programs, (3) System-Wide Focus of Leadership, (4) Integration of Health, Wellness with Behavioral Health, (5) Workforce Development, (6) Community Connections and Resources, (7) Self- Management Language and Messaging, (8) Workforce Wellness, (9) Organizational Policies, and (10) Performance Evaluation and Data		Organization has not yet demonstrated awareness of the need to support workforce wellness.	Organization is aware of value of supporting the wellness of their workforce, but has not yet developed a plan to address it.	Organization is actively reviewing workforce for causes of burnout and toxic stress and a workforce wellness plan has been developed. Staff perspective on the quality of workforce wellness is assessed and acted upon.	All aspects of the workforce wellness plan have the 5 listed characteristics. The plan has been approved by staff. Workforce wellness is an ongoing effort and at least 70% of staff are aware of one or more wellness activities, but funding and leadership support are limited. If key staff leave, the initiative may not continue.	Workforce wellness is supported as its own stand-alone initiative. Funds are not diverted to support other efforts. The process on the quality of workforce wellness is utilized and responded to by leadership. 75-100% of participants report that wellness activities are inclusive, they use them regularly, and are a positive experience. Workforce wellness is codified in policies, procedures, practices, activities, services, and social and physical environments.
Comment or justification for score: ***Suggested metric:*** *Number of paid staff: ___. Number and percent (subset) who report awareness of at least one identified wellness activity ____ (___%). SAMHSA/HRSA Culture of Wellness Implementation Score and Date: _____*						

Element #2: Train

Develop a competent, confident and caring workforce.

Assessment of Workforce Confidence	Rating	1	2	3	4	5
How does the organization formally assess staff on their perception of their confidence, skills, and level of support to care for individuals at risk for suicide?		Organization has not yet demonstrated awareness of the need for a formal assessment of staff on their perception of confidence, skills, and perceived support in providing suicide care.	Organization is aware of value of a formal assessment, but has not yet developed the assessment.	A formal assessment has been developed. Clinical staff who provide direct care were involved in the development.	A formal assessment of staff perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive organizational training plans are tied to the results.	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 staff needs.
Comment or justification for score:						

Trainings for Non-Clinical Staff	Rating	1	2	3	4	5
What basic training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff?		Organization has not yet demonstrated awareness of the need for an organization-supported training on suicide care and there is no requirement for non-clinical staff to complete training on suicide risk identification.	Organization is aware of the value of suicide risk identification and care training for non-clinical staff but has not yet developed a training plan.	A plan to train all non-clinical staff in suicide risk identification and care has been developed.	Training on suicide risk identification and care is required of all staff. 50-75% of non-clinical staff are trained. The training used is considered a best practice and was not internally developed. Competency assessments are being developed.	75-100% of non-clinical staff are trained and trainings are repeated at regular intervals. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result.
Comment or justification for score:						

Trainings for Clinical Staff	Rating	1	2	3	4	5
What advanced training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff?		Organization has not yet demonstrated awareness of the need for organization-supported training on suicide safer care. There is no requirement for clinical staff to complete training on suicide.	Organization is aware of the value of suicide risk identification and care training for clinical staff but has not yet developed a training plan.	A plan to train all clinical staff in suicide risk identification, suicide assessment, risk formulation, and ongoing management has been developed.	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 and was not internally developed. 50-75% of clinical staff are trained. Competency assessments are being developed.	75-100% of clinical staff are trained and trainings are repeated at regular intervals. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result.
Comment or justification for score:						

Element #3: Identify

Systematically identify and assess suicide risk among people receiving care.

Screening for Suicide Risk	Rating	1	2	3	4	5
What are the organization's policies for screening for suicide risk?		Organization has not yet demonstrated awareness of the need to systemically screen for suicide risk.	Organization is aware of the value of a policy for systemically screening all individuals at intake for suicide risk but has not yet developed a plan to create the policy.	A policy to screen all individuals (health, behavioral health, support services, etc.) at intake has been developed.	A policy to screen every individual at intake is in place. The policy includes reassessing individuals in designated higher-risk programs or categories (e.g., crisis calls) at every visit and when an individual has a change in status: (level of care, setting, provider, or risk factors/life circumstances, such as divorce, unemployment, or diagnosed illness).	Screening practice is codified in policy and the policy is followed. Screening is documented in the EHR and quality improvement processes are in place (e.g., monthly provider review of rate of positive screens).
Comment or justification for score: *Metric: Percent of individuals enrolled in previous month who were screened for suicide risk.*						

Screening Tools Used	Rating	1	2	3	4	5
How does the organization screen for suicide risk in the people it serves?		Organization has not yet demonstrated awareness of the need for a validated screening tool.	Organization is aware of the need for a validated screening tool and required staff training, but a plan to train staff has not yet been developed.	Organization has developed a plan to train all staff on the validated screening tool. The plan includes assessing staff for competency at regular intervals.	50-75% of staff are trained on a validated screening tool. The tool is required to be used by all staff.	75-100% of staff are trained to use the required screening tool. Staff are assessed for competency at regular intervals, and results lower than full competency are incorporated into future trainings and the training plan is modified as a result.
Comment or justification for score: Suicidality screening tool used:						

Suicide Risk Assessment	Rating	1	2	3	4	5
How does the organization assess suicide risk among those who screened positive?		Organization has not yet demonstrated awareness of the need for a suicide risk assessment that is (1) validated, (2) includes protective factors, and (3) risk formulation.	Organization is aware of the value of a risk assessment that includes all 3 elements, but has not yet developed a plan to systematically assess individuals who screen positive for suicide risk on the day they screened positive.	A suicide risk assessment plan had been developed that includes (1) assessing suicide risk on the same day as a positive screen, (2) training staff on a validated assessment tool and approach, (3) documenting assessments in medical records, and (4) integrating risk assessments into treatment sessions for individuals at risk.	All individuals with risk identified, at any point during care, are assessed by clinicians who use validated instruments and who have received training on the tool and approach. Assessment includes both risk and protective factors. Suicide risk assessments are documented in the medical records. Competency assessments to ensure clinicians are assessing risk with fidelity to the validated tool are being developed.	Quality improvement processes are in place to review risk assessment protocol. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result.
Comment or justification for score: *Metric: In the past full month: Percent of individuals in care who screened positive for suicide risk who also had a comprehensive risk assessment on the day they screened positive. Risk Assessment Tool used: _____*						

Element #4: Engage

Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet individual needs.

Care for Individuals At-Risk for Suicide	**Rating**	**1**	**2**	**3**	**4**	**5**
Which best describes the organization's approach to caring for and tracking people at risk for suicide?		Organization has not yet demonstrated awareness of the need to create a consistent approach to suicide care management.	Organization is aware of the value of a consistent approach to care for people at risk for suicide, but protocols and polices to do so are not yet developed.	Organization has developed policies or protocols for care management for individuals at different risk levels, frequency of contact, care planning, and safety planning. A plan to train all providers to provide care to those at risk for suicide has been developed.	Protocols or policies for care management for individuals with suicidal thoughts or behaviors are in place and followed. Individuals at risk for suicide are placed on a suicide care management plan. Electronic or paper health records are enhanced to embed all suicide care management components listed above. Information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the organization's suicide care management approach and how engage individuals empathetically.	The organization has a consistent approach to suicide care management. Protocols for putting someone on and taking someone off a care management plan are clear. Staff hold regular case conferences about individuals who remain on suicide care management plans beyond a certain time frame, which is established by the implementation team.
Comment or justification for score: *Suggested metric: Type of empathetic communication skills training used: Motivation Interviewing Reflective Communication*						

Collaborative Safety Planning	Rating	1	2	3	4	5
What is the organization's approach to collaborative safety planning when an individual is at risk for suicide?		Organization has not yet demonstrated awareness of the need to create a consistent approach to collaborative safety planning.	Organization is aware of the value of a consistent approach to collaborative safety planning, but there is no formal guidance or policy around content. There is no standardized safety plan or documentation template.	Policy for collaboratively creating a safety plan on the same day as the individual is assessed for suicide risk has been developed.	Safety plans are developed according to policy, which includes: (1) risks, (2) triggers, and (3) concrete coping strategies, prioritized from most natural to most formal or restrictive. The safety plan is shared with the individual's support system (with consent). All staff use the same safety plan template and are trained in collaborative safety plan best practices.	Safety plans are reviewed and modified as needed at every visit with a person at risk. Other clinicians involved in care or transitions are aware of the safety plan. Staff are assessed for competency at regular intervals. Competency assessment results lower than full competency are incorporated into future trainings and the training plan is modified as a result. The safety plan policy is reviewed by the ZS implementation team regularly and updated as needed.
Comment or justification for score: Safety planning tool used: _____ *Metric: In the past full month: Percent of individuals in care who were screened and assessed positive for suicide risk who also had a comprehensive safety plan developed on the same day.*						

Lethal Means Counseling	Rating	1	2	3	4	5
What is the organization's approach to lethal means counseling?		The organization has not yet demonstrated awareness of the need for lethal means counseling.	Organization has demonstrated awareness of the need for lethal means counseling but how and who to ask about lethal means are up to individual clinician's clinical judgment. Means counseling is rarely documented. The organization may not yet provide any training on lethal means counseling.	Means counseling is included on all safety plans. The organization provides training on counseling on access to lethal means. Steps to reduce means are up to the individual clinician's judgment. The at-risk individual's support system may or may not be involved in reducing access to lethal means. Strategies for reducing access are expected to be included on safety plans for all individuals identified as at risk for suicide.	All of the above, plus support person(s) are included in planning means counseling. The organization has policies regarding the minimum actions for limiting access to means.	All of the above, plus contacting a support person(s) to confirm temporary removal or securing is the required, standard practice. At least 75% of clinical staff are trained on counseling on access to lethal means. Means counseling recommendations and plans are reviewed regularly while the individual is at an elevated risk. Policies support these practices and adherence to these policies are reviewed at least annually.
Comment or justification for score: *Metric: In the past full month: Percent of individuals in care who were screened and assessed positive for suicide risk who also had a comprehensive safety plan developed on the same day. Date of most recent lethal means chart review: _____*						

Postvention for staff and individuals in care (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
Does your organization include postvention in their continuum of care for staff and individuals in care? Is it codified in policies and practice?		The organization has not yet demonstrated awareness of the need for postvention policies and procedures.	The organization has demonstrated awareness of the need for a postvention plan/process that identifies and links affected staff and individuals in care to additional support resources. A designated postvention coordinator may have been identified, but planning has not yet begun.	A postvention and communication plan that facilitates healing and addresses potential contagion has been developed. A coordinator is in place with dedicated funds for implementing the plan. The communication plan includes safe messaging, easy access to a continuum of supports (peer support, debriefing opportunities, EAP) and safe memorialization practices, but supervisors/ managers may not yet know how to support staff and connect them with these supports.	Postvention supports, delivered by internal teams, external teams, EAP or other, are available and provided BEFORE the incident review, which is conducted by a separate team. 50-75% of staff are aware of the protocols. Additional care is provided to the trained postvention team. Staff and individuals in care do not fear that what they say during postvention will be used against them. Affected staff do not feel blamed and are offered support in the wake of a suicide attempt/death. Easy access to support continues at least through the one-year anniversary.	75-100% of staff have been trained and at least 80% of staff feel confident to respond to a suicide death per agency protocol. Protocols are reviewed and updated annually. Training is part of on-boarding new staff. Postvention plan includes root cause analysis/critical incident review. Staff are confident in their organization's ability to follow the postvention plan. Staff have tools and skills for responding to all forms of grief that can occur in the workplace (grief readiness).
Comment or justification for score: *Suggested metric: Number of current staff: _____ Number and Percent who have been trained in postvention policies and practices: _____ (___%) Percent who feel Very or Totally Confident in responding per agency protocol: _____ Percent who feel Very or Totally Confident in responding to grief in the workplace: _____*						

Postvention for affected community members (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
How does the organization engage with the broader community affected by a suicide attempt or death?		The organization has not yet demonstrated awareness of the need for a continuum of care for the broader community.	The organization has demonstrated awareness of the need to engage with the broader community (extended family members, schools, employers, the media) following a suicide attempt or death. A designated postvention coordinator may have been identified, but planning has not yet begun.	A communication plan is in place and includes safe messaging, internal and external resources, and safe public memorialization practices. The postvention plan includes pulling in external supports, such as county postvention coordinators, to support affected community members. The postvention team is coordinating with external postvention response resources.	The communication plan has been shared with staff and community partners and is followed. There are provisions for culturally appropriate and community specific postvention. 50-75% of staff are aware of the communication plan. Memorialization practices follow the plan. Behavioral health supports and other resources are in place and accessible.	The communication plan is reviewed and updated annually with the response team and community partners. 75-100% of staff are aware of the communication plan and are confident that the organization will communicate with affected community members and partners following a suicide attempt or death. Staff have tools and skills for responding to all forms of grief that can occur in the community (grief readiness).
Comment or justification for score:						

Element #5: Treat

Use effective, evidence-based treatments that directly target suicidality.

Access to Suicide-specific Treatment	**Rating**	**1**	**2**	**3**	**4**	**5**
How does the organization ensure access to quality treatment for suicidal thoughts and behaviors?		The organization has not yet demonstrated awareness of the need for evidence-based treatments for suicide care, sustained staff training on care models, or additional treatment modalities for people with chronic symptoms.	The organization has demonstrated awareness of the need but has neither identified an external provider nor chosen an evidence-based model (CAMS, CBT-SP, or DBT) to use in-house.	The organization has developed a plan to provide or refer individuals with suicide risk to empirically-supported treatment models. If provided in-house, a training plan has been developed, not yet implemented.	Staff and individuals served have access to evidence-based and/or culturally appropriate suicide specific treatment either in-house, via telehealth, or through referrals. There are robust processes to connect people to appropriate resources in the community. Staff and individuals served are aware of how to access suicide specific services. However, staff training may not be regular or recurring, and monitoring for treatment model changes may not take place.	The organization includes input from people with lived experience in the regular monitoring of their treatment approach. 100% of relevant in-house or external staff are trained in evidence-based treatments and a staff training plan is regularly monitored. Fidelity to EB suicide specific interventions is maintained and documented. Modifications to EBPs are documented and logical for the population. 80% of trained staff report feeling confident to work with someone experiencing suicidal ideation.
Comment or justification for score: *Metric: Percent of clinical staff trained in a specific suicide treatment model (Specify model: _____)*						

Safer Environment (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to management of risks in the physical environment that could be used to attempt suicide?		The organization has not yet demonstrated awareness of the need to manage potential risks in the physical environment nor train staff to ensure comfort to address safety concerns.	The organization has demonstrated awareness of the need to review the physical environment for safety concerns, but the environment has not yet been reviewed.	The organization has conducted a risk assessment to identify potential environmental hazards to individuals who are at high risk for suicide and acted to safeguard them from these risks. Written policies are being developed.	There are written policies for keeping individuals in suicidal crisis safe under appropriate levels of direct supervision. Philosophy of least restrictive care is embedded in policy. Policies exist for one to one monitoring, safe storage of personal belongings, and removal of objects that could be used for self-harm (bell cords, bandages, gowns with strings, plastic bags, cleaning supplies). Anchor points, door hinges and hooks are reviewed for safety.	The organization reviews the physical environment according to industry standard, at least annually, and makes changes as a result. Staff are trained on policies and safety procedures and are comfortable speaking about safety concerns. Safety concerns are reviewed and changes are made as a result.
Comment or justification for score:						

Element #6: Transition

Provide continuous contact and support, especially after acute care.

Engaging Hard to Reach Individuals	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to engaging hard-to-reach individuals or those who are at risk and don't attend appointments?		The organization has not yet demonstrated awareness of the need to reach those at elevated suicide risk who don't show for scheduled appointments.	The organization has demonstrated awareness of the need to reach those at elevated suicide risk who don't show for scheduled appointments but a plan to do so has not yet been developed.	The organization has developed a plan to follow-up for individuals with suicide risk who don't show for appointments. The plan includes active outreach and includes input from people with lived experience, but the plan is not fully implemented.	The organization is actively implementing their follow-up plan, but the process may not yet be sustainable or monitored.	The follow-up plan is in place, routinely utilized, and practicable. The plan is sustainable and routinely monitored for continuous quality improvement, including input from people with lived experience.
Comment or justification for score:						

Follow-up after Transitions in Care	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to following up with individuals who have recently been transitioned from acute care settings (e.g., emergency departments, inpatient psychiatric hospitals) and/or crisis contact, non-engagement in services, or other transitions?		The organization has not yet demonstrated awareness of the need to follow up with those at elevated suicide risk following discharge from acute care settings.	The organization has demonstrated awareness of the need for follow-up for individuals with suicide risk, but a plan, that includes input from people with lived experience, as not yet been developed.	The organization has developed a plan to follow-up with individuals with suicide risk after discharge from acute care settings (e.g. crisis contact, transition from an emergency department, or transition from psychiatric hospitalization), but the plan may not be fully implemented.	The organization has a follow-up plan in place but it is not sustainable or monitored. If key staff leave, follow-up may not continue.	The follow-up plan is in place, routinely utilized, and practicable. The plan is sustainable and routinely monitored for continuous quality improvement, including input from people with lived experience.
Comment or justification for score:						

Element #7: Improve:

Apply a data-driven quality improvement approach to inform system changes leading to better care and improved outcomes for individuals at risk.

Analysis of Suicide Deaths	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to reviewing deaths for those enrolled in care?		The organization has not yet demonstrated awareness of the need to conduct a root cause analysis (RCA) or incident review of suicide deaths by individuals in care.	The organization is aware of the need to conduct RCA or incident review on deaths by suicide, but they do not yet regularly conduct them.	The organization has developed a procedure to conduct RCA or incident review on all deaths by suicide for people in the organization (including deaths up to 6 months past case closed) that includes provisions to update policies and training as a result.	A procedure to conduct RCA or incident review on all suicide deaths of people in the organization and on deaths up to 6 months past case closed is in place. The procedure includes updating policies and training as a result, but the procedure may not be monitored or sustainable.	A procedure for RCA or incident review is in in place, monitored and sustainable. Individuals with lived experience provide input on how to improve care for those after a suicide death. Policies and training are updated as a result.
Comment or justification for score: *Metrics: (1) Number of days since most recent root cause analysis of a suicide death* *(2) Number of days since most recent suicide death (a) of someone in care and (b) of someone who had left care less than 6 months before suicide death.*						

Tracking Suicide Deaths	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to measuring suicide deaths?		The organization has not yet demonstrated awareness of the need to measure suicide deaths for those enrolled in their care.	The organization is aware of the need to measure the number of deaths for those who are enrolled in care for up to 6 months past case closed, but has not yet developed a plan to do so.	The organization has developed a plan to measure all suicide deaths for enrolled individuals in care for up to 6 months past case closed but it may not be fully implemented. The plan may include cross referencing state vital statistics data or other federal data.	The organization measures suicide deaths for those enrolled in care and for 6 months past case closed using verified databases, but this process may not continue if key staff leave.	The organization has a policy or procedure related to measuring suicide deaths, at least annually, that is informed by input from people with lived experience.
Comment or justification for score: *Metrics: (1) Date measurement for suicide deaths was established. (2) Date of most recent annual crosswalk of enrolled individuals against vital statistics data.*						

Analysis of Suicide Attempts (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to reviewing attempts for those enrolled in care?		The organization has not yet demonstrated awareness of the need to conduct a root cause analysis (RCA) or incident review of suicide attempts by individuals in care.	The organization is aware of the need to conduct RCA or incident review on suicide attempts, but they do not yet regularly conduct them.	The organization has developed a procedure to conduct RCA or incident review on all suicide attempts for people in the organization that includes provisions to update policies and training as a result.	A procedure to conduct RCA or incident review on all suicide attempts of people in the organization is in place. The procedure includes updating policies and training as a result, but the procedure may not be monitored or sustainable.	A procedure for RCA or incident review is in in place, monitored and sustainable. Individuals with lived experience provide input on how to improve care for those after an attempt. Policies and training are updated as a result.
Comment or justification for score: *Metrics: (1) Number of days since most recent root cause analysis of a suicide attempt (2) Number of days since most recent suicide attempt (a) of someone in care and (b) of someone who had left care less than 6 months before suicide attempt.*						

Tracking Suicide Attempts (NEW)	**Rating**	**1**	**2**	**3**	**4**	**5**
What is the organization's approach to measuring suicide attempts?		The organization has not yet demonstrated awareness of the need to measure suicide attempts for those enrolled in their care.	The organization is aware of the need to measure the number of attempts for those who are enrolled in care for up to 6 months past case closed, but has not yet developed a plan to do so.	The organization has developed a plan to measure all suicide attempts for enrolled individuals in care for up to 6 months past case closed but it may not be fully implemented. The plan may include cross referencing state vital statistics data or other federal data.	The organization measures suicide attempts for those enrolled in care and for 6 months past case closed using verified databases, but this process may not continue if key staff leave.	The organization has a policy or procedure related to annually measuring suicide attempts that is informed by input from people with lived experience.
Comment or justification for score: *Metrics: (1) Date measurement for suicide attempts was established. (2) Date of most recent annual crosswalk of enrolled individuals against vital statistics data.*						

Appropriateness of Suicide Safer Care (NEW)	Rating	1	2	3	4	5
How appropriate are the chosen suicide prevention strategies for those being served, including (1) identification, (2) engagement, (3) suicide-specific treatments, (4) care transitions, (5) postvention and (6) training?		The organization has not yet demonstrated awareness of the need to match safer suicide care with lived experience and/or chronic symptoms nor of the need for multiple modalities.	The organization has demonstrated awareness of the need for multiple modalities, but specific elements of safer suicide care have yet to be reviewed for appropriateness for the target population.	The organization has developed a plan to reviewed for all 6 modalities for appropriateness for the target population, but not all have yet been systematically reviewed or adapted.	The organization has reviewed at least 4 of the 6 components of suicide prevention and has added multiple options or adaptations as appropriate. A plan is in place to assess the appropriateness of specific modalities for each individual in care through chart review, supervision and/or direct consumer input.	All of the above, plus the organization reviews all components of suicide safer care at least annually to meet their changing population and emerging best practices.
Comment or justification for score: *Metric: Percent of clinical staff trained in a specific suicide treatment model (Specify model: _____)*						

Continuous Quality Improvement (CQI)	Rating	1	2	3	4	5
What is the organization's approach to quality improvement activities related to suicide prevention?		The organization has not yet demonstrated awareness of the need to integrate suicide safer care into quality improvement activities.	The organization is aware of the need to integrate suicide safer care into quality improvement activities but has not yet developed a plan to do so.	The organization has developed a plan to integrate suicide safer care into quality improvement processes.	Quality improvement processes include activities related to suicide safer care. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to organizational policies. However, if key staff leave, chart reviews and QI activities that include suicide safer care may not continue.	Quality improvement processes that include suicide safer care are ongoing and occur regularly. Data from EHR or chart reviews are routinely examined (at least quarterly) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows are updated regularly as the team reviews data and makes changes.
Comment or justification for score: *Metric: Most recent date that data from EHR or chart reviews were examined for adherence to suicide care policies.*						