2021 Hospital Quality Incentive Payment (HQIP) Program

Zero Suicide Measure

February 6, 2020

CHASE

Colorado Healthcare Affordability and Sustainability Enterprise

I. Zero Suicide Measure

Zero Suicide is a new measure being introduced to the Patient Safety measure group in the 2021 HQIP program year. Hospitals will earn points for the successful completion of levels. Levels are cumulative, for example, hospitals must complete level I to be eligible to earn points for completing level II. In order to receive the highest points, hospitals must complete all four levels. The four levels of this measure are:

Level I: Leadership and Planning
Level II: Training
Level III: Identify, Treat, Engage
Level IV: Transition and Improve

Level I: Leadership and Planning

1. **Leadership Buy-In**
    a. **Deliverable:** Hospitals must submit a written commitment from CEO/leadership highlighting that suicide prevention is a core priority of the health system.
    b. **Deliverable**: Hospitals must submit a formal plan to begin implementation of the framework, including conducting an annual organizational self-survey[1] and an annual workforce survey[2]

2. **Implementation Team**
    a. Health system forms a Zero Suicide implementation team that meets regularly and drives Zero Suicide work forward. The team will include representation from clinical workforce, non-clinical workforce, IT/data specialist, quality improvement specialist. Ideally the team would also include, a person with lived experience of receiving care in the health system.
    b. **Deliverable:** Hospitals must submit a description of the implementation team, its membership and qualifications.

3. **Organizational Self-Survey**

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[1] See Level I.3.a
[2] See Level II.1.a

a. **Deliverable:** Implementation team must take and submits the survey annually, identifying opportunities for system improvement and participate in the monthly Zero Suicide learning collaborative hosted by the Office of Suicide Prevention.
    i. Resource: Organizational Self-Survey
    ii. Resource: Team participation in the monthly Zero Suicide learning collaborative hosted by the Office of Suicide Prevention

4. **Work Plan**

a. **Deliverable**: The hospital must submit a plan for implementing Zero Suicide framework within the health system that identifies strengths, weaknesses, opportunities for improvements, systemic barriers, and additional resource needs.
    i. Resource: Zero Suicide Work Plan Template

Level II: Training

1. **Workforce Survey**

a. **Deliverable**: The implementation team must administer the workforce survey annually and submit results.
b. Survey results are used to formulate training plans and other system changes.
    i. Resource: Workforce Survey

2. **Non-clinical Workforce Training**

a. All non-clinical staff should receive gatekeeper-level[3] or better suicide prevention training. Staff that have the most interaction with patients (front desk staff, customer relations) should get priority, but the goal of the program is to train 100% of health system staff.
b. **Deliverable**: The hospital must submit a training plan that includes what curricula the system will use for non-clinicians, how trainings will be implemented, how they will be tracked, plans for sustainability of training, list of needed resources. Examples of acceptable trainings are:

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3 Gatekeeper training provides an overview of suicide prevention. Participants learn how to recognize suicidal behavior, how to respond, and where to make a referral and find help. It does not teach how to do a clinical assessment of a person at risk for suicide. See: http://zerosuicide.sprc.org/toolkit/train#quicktabs-train=2

i. Applied Suicide Intervention Skills Training (ASIST)
ii. Question, Persuade, Refer (QPR): Gatekeeper Training for Suicide Prevention
iii. Suicide Alertness for Everyone: Tell, Ask, Listen, and Keep Safe (safeTALK)

c. **Deliverable**: The hospital must create and submit an annual report that includes number and percentage of non-clinical staff trained.
    i. Resource: Office of Suicide Prevention can provide training modules and materials.

3. **Clinical Workforce Training**
    a. The goal of the program is for all clinicians should receive suicide prevention training relevant to their roles within a system. Trainings must cover core competencies of screening, assessment, safety planning, and lethal means counseling[4]. Some trainings, like Collaborative Assessment and Management of Suicidality (CAMS) cover more than one of these competencies. Other skills relevant to clinicians' duties, such as intake, discharge planning, and follow-up services should be included in training plans to meet varying needs of system clinicians. Examples of acceptable trainings are:
        i. Assessing and Managing Suicide Risk (AMSR)
        ii. Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS)
        iii. Counseling on Access to Lethal Means (CALM)
        iv. Collaborative Assessment and Management of Suicidality (CAMS)
        v. Safety Planning Intervention for Suicide Prevention
    b. **Deliverable**: The hospital must submit a training plan that includes what trainings are selected to meet various needs, how they will be implemented, how they will be communicated to clinical staff as well as medical staff (including key personnel for program staff not employed by the hospital), how they will be tracked, how trainings will be sustained, and what additional resources are needed.

[4] Lethal means counseling helps reduce access to the methods people use to kill themselves including firearms and potentially dangerous medications.

c. **Deliverable**: The hospital must submit an annual report that includes number and percentage of staff that have received each type of identified core competency training (screening, assessment, safety planning, and lethal means counseling) and additional trainings.
    i. Resource: Office of Suicide Prevention can connect teams with training modules, training events and other resources

Level III: Identify, Treat, Engage

1. **Screening**
    a. Screening procedures applicable for all patients are implemented (gold standard is universal screening). Screening procedures that ensure that 100% of individuals who screen positive for suicide risk are provided with full assessment for safety, collaborative safety planning and lethal means counseling (i.e. what tool(s) will be used, what staff will administer, when, what training is necessary to achieve this, what EHR tools are available to assist and track)
    b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who were screened for suicide risk and how many of those people screened positive in the prior year.
2. **Assessment**
    a. Assessment procedures to ensure that 100% of individuals who screen positive for suicide risk are provided with full assessment for safety
    b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who screened positive for suicide risk who received a safety assessment
3. **Safety Planning**
    a. Policy and procedures that ensure 100% of individuals who screen positive for suicide risk work with a clinician to create an effective (ideally a collaborative) safety plan
    b. **Deliverable**: On an annual basis, submit a report including the number and percentage of individuals who screened positive for suicide risk who received a safety plan.

Level IV: Transition and Improve

1. **Follow-Up**

All individuals who screen positive for suicide risk should receive follow-up contacts from health system after inpatient, outpatient, or emergency visits.

a. **Deliverable** (internal process)
    i. Submit a written policy and work plan for following up within 3 calendar days for clients who screen positive for suicide risk that includes which staff are responsible for making contact and what system is used to track implementation.
    ii. On an annual basis submit reports with number and percentage of individuals who screened positive for suicide risk who received a follow-up contact (phone call, text, email, etc.) within 3 days of discharge

b. **Alternative Deliverable**: Documentation that the health system participates in the Colorado Follow-Up Project in partnership with the Office of Suicide Prevention and Rocky Mountain Crisis Partners

2. Data Tracking

a. **Deliverable**: The hospital must have the capability to track screening, assessment, safety planning, and lethal means counseling built into its system (electronic health record, other electronic or manual system) in order to track compliance with written policies

b. **Deliverable**: The hospital must document utilization of a data monitoring tool to track implementation of written policies, training plans, return ED visits, suicide attempts, and suicide fatalities of clients using the measures documented in the data elements worksheet.
    i. Resource: Data Elements Worksheet

Scoring

Hospitals will earn points for the successful completion of four levels. Levels are scored cumulatively. In order to receive the highest points, hospitals must complete all previous levels.

Total	Level 1	Level 2	Level 3	Level 4
10	3	5	7	10