



Cooperative Agreements to Implement Zero Suicide in Health Systems

Pre-application Webinar
FOA No. SM-17-006

June 02, 2017, 2:00-3:00pm EST

Please stand by. This conference will begin shortly.
For audio, **dial: 800-857-2949** **Passcode: 8457687**



Welcome!

Providing review

Point of Contact for programmatic issues
and concerns during application and review

Grant project officer for Zero Suicide
program

Also project officer for the National Suicide
Prevention Lifeline, Crisis Center Follow Up,
National Strategy for Suicide Prevention
grants and Garrett Lee Smith Youth Suicide
Prevention program



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The Need for the Zero Suicide Grant Program



Richard McKeon, Ph.D.

Branch Chief

Suicide Prevention Branch

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

SAMHSA's Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development

Zero Suicide Grant Program

- 1st Round of Zero Suicide
- Cooperative Agreement
- \$7.9 million (\$2 million for tribes)
- 13 estimated awards
- Up to 5 years
- Applications due July 18, 2017

Eligibility

- State Government Health Agencies, including the District of Columbia and U.S. Territories, with Mental Health and/or Behavioral Health Functions (up to \$700,000 a year)

\$400,000 a year

- Indian tribe or tribal organizations (further defined in FOA)
- Community-based primary care or behavioral health care organizations
- Emergency departments
- Local public health agencies

Criteria for Community Mental Health Centers

- Provide services primarily to individuals residing in a defined geographic area (service area)
- Provide outpatient services, including specialized services for individuals with SMI and the elderly and residents of the service area who have been discharged from inpatient treatment at a mental health facility
- Provide 24 hour emergency care services
- Day treatment or other partial hospitalization services, or psychosocial rehabilitation services
- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission

* See Section 1913(b)(1) of the PHS Act

Criteria for Primary Health Services

- Provides basic health services (family medicine, internal medicine, gynecology, obstetrics, etc.) by physicians, physicians assistants and/or nurse practitioners
 - Provides diagnostic laboratory and radiological services
 - Preventative health services (screenings, immunizations, family planning, etc.)
 - Emergency medical services
 - Pharmaceutical services as appropriate

Criteria for Primary Health Services Cont.

- Provides referrals to other medical services including specialty referrals when medically indicated and other health related referrals (including mental health and substance abuse services)
- Provides case management services (including counseling, referral, and follow-up services)
- Additional services as needed to enable individuals to use the services of the health center

* See Section 330(b)(1)(A) of the PHS Act

National Strategy Grants

- SAMHSA also released FY 2017 Funding Opportunity Announcement “Cooperative Agreements to Implement the National Strategy for Suicide Prevention (SM-17-007).
- Applicants who have submitted an application for National Strategy Grants may also apply for a Zero Suicide grant. However, an applicant organization may only receive one award: either a National Strategy grant or a Zero Suicide grant. If both applications are in the fundable range, applicants will receive the Zero Suicide award.

Program Overview

- Purpose: The purpose of this program is to implement suicide prevention and intervention programs that are designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk for suicide. Grantees will implement the Zero Suicide model throughout their health system/s.
- Focus: transforming health systems who treat age 25 and older.

Why do we need this program?

- Middle-aged adults have the highest number of deaths by suicide nationwide. ⁽¹⁾
- Middle-aged adults (whose rates increased 35% from 2000 to 2015, with steep increases seen among both males (29%) and females (53%) aged 35–64 years); ⁽²⁾
- Overall suicide rates increased 28% from 2000 to 2015. Suicide is a problem throughout the life span; the second leading cause of death among people 25–34 years of age; the fourth leading cause among people 35 to 44 years of age, the fifth leading cause among people ages 45–54 and eighth leading cause among people 55–64 years of age. ⁽²⁾
- In 2010, more than 70 percent of the suicides in the U.S. took place among adults between ages 25-64. ⁽³⁾

1. CDC MMWR, 67(17): 321-325.

2. Centers for Disease Control and Prevention. Web-Based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control.

3. CDC Fatal Injury Data, 1999-2010 US Suicide Deaths.

Why do we need this program?

- 45% of those who died by suicide saw a primary care provider in the 30 days before they died
- 10% of those who died were seen in an emergency room in the two months prior to their death
- About 30% of all suicide deaths are among those who received behavioral healthcare
- The rate of suicide seen among those care for in state mental health systems has been reported to be as high as 140 in 100,000, or 10 times the national rate

* Reported from *Suicide is a Significant Health Problem*. Hogan, 2017

Zero Suicide Model

Comprehensive strategy for healthcare transformation that includes 7 core elements

- **Lead** - Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles;
- **Train** - Develop a competent, confident, and caring workforce;
- **Identify** - Systematically identify and assess suicide risk among people receiving care;
- **Engage** - Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means

Zero Suicide Model

- **Treat** - Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors
- **Transition** - Provide continuous contact and support, especially after acute care
- **Improve** - Apply a data-driven, quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

<http://zerosuicide.sprc.org/>

Program Overview & Goals

- Healthcare systems that focus on adults age 25 and older
- A Zero Suicide approach should be a comprehensive, multi-setting approach to suicide prevention in health systems.
- Work within health systems, including behavioral health, to identify, assess, treat, refer and follow up with suicidal individuals. Health systems that do not provide direct care services may partner with agencies that can implement the Zero Suicide model.
- For communities without well-developed behavioral health care services, the Zero Suicide model may be implemented in Federally Qualified Health Centers or other primary care settings.

So how do we do that?

Required activities!

- Improve and implement services
- Infrastructure development
- Evidence-based practices
- Data-collection and performance measurement
- Local performance assessment

Services

- Screen all individuals receiving care for suicidal thoughts and behaviors. Conduct a comprehensive risk assessment of individuals identified at risk for suicide, and ensure reassessment as appropriate.
- Implement effective, evidence-based treatments that specifically treat suicidal ideation and behaviors. Clinical staff must be trained to provide direct treatment in suicide prevention and evaluate individual outcomes throughout the treatment process.
- Transform health systems to include a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, and to accept and embed the Zero Suicide model within their agencies.

Services

- Train the health care workforce in suicide prevention evidence-based, best-practice services relevant to their position, including the identification, assessment, management and treatment, and evaluation of individuals throughout the overall process.
- Work with Veterans Health Administration (VHA) and community-based outpatient clinics, state department of veteran affairs, and national SAMHSA and Veterans Administration (VA) suicide prevention resources to engage and intervene with veterans at risk for suicide but not currently receiving VA services. This includes veterans contacting local Lifeline crisis centers, sub-acute crisis services, and community emergency departments.

Brief Word from VA

Dr. David Carroll

U.S. Department of Veterans Affairs

Services

- Develop a Suicide Care Management Plan for every individual identified as at-risk of suicide and continuously monitor the individual's progress through their electronic health record (EHR) or other data management system, and adjust treatment as necessary.
- For State applicants, ensure that at least 70 percent of the Suicide Prevention Lifeline calls are answered by a Suicide Prevention Lifeline Crisis center within the state from which the call originated, excluding callers who press "1" to be connected to the Veterans Crisis Line.
- Ensure feedback and leadership of survivors of suicide attempts and suicide loss are involved in all required activities.

*Refer to FOA for full list of required services

Lifeline In-State Answer Rates (Q2-FY17)

AK - 65%	HI - 91%	MO - 91%	PA - 28%
AL - 72%	IA - 69%	MS - 51%	RI - 24%
AR - 0%	ID - 78%	MT - 89%	SC - 77%
AZ - 92%	IL - 33%	NC - 87%	SD - 66%
CA - 85%	IN - 62%	ND - 87%	TN - 73%
CO - 92%	KS - 72%	NE - 75%	TX - 21%
CT - 79%	KY - 27%	NH - 83%	UT - 93%
DC - 60%	LA - 92%	NJ - 84%	VA - 62%
DE - 87%	MA - 66%	NM - 85%	VT - 2%
FL - 78%	MD - 92%	NV - 60%	WA - 41%
GA - 22%	ME - 92%	NY - 32%	WI - 28%
	MI - 44%	OH - 78%	WV - 39%
	MN - 65%	OK - 85%	WY - 0%
		OR - 86%	

<http://suicidepreventionlifeline.org/our-network/>

Infrastructure Development

- Developing partnerships with other service providers for service delivery.
- Adopt or enhance your computer system, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support systems, and outcomes. **Enhancing system to track suicides and suicide attempts.**

Infrastructure Development

- Training/workforce development to help your staff or other providers in the community identify mental health or substance abuse issues or provide effective services consistent with the purpose of the grant program.
- You may use **no more than 15 percent** of the total services grant award for the following types of infrastructure development, if necessary, to support the direct service expansion of the grant project

Data Collection

- Assess and demonstrate the impact of grant activities on adult suicide deaths and attempts within selected health system by utilizing, modifying or creating timely surveillance data at the beginning, during, and end of grant.
- Modify your efforts during the grant based on this surveillance data.
- **No more than 20 percent** of the total grant award may be used for data collection, evaluation, performance measurement, and performance assessment, including incentives for participating in the required data collection follow-up.

Performance Measurement

- Reported quarterly
 - Number of individuals trained
 - Number of organizations implementing specific mental health related practices
 - Number of individuals screened for suicidal behavior
 - Number of individuals receiving care because of the grant
 - number and percentage of work group/advisory group/council members who are consumers/family members
 - Number and % of individual receiving MH or related services after referral

...as a result of your grant.

Local Performance Assessment

- Will help you determine whether you are achieving the goals, objectives, and outcomes you intend to achieve, what you need to adjust to meet your goals, and determine if you're having the impact you think you're having.
 - Within your program, how did your grant activities impact suicide deaths and non-fatal suicide attempts in selected health and behavioral healthcare systems?
- See page 12 and 13 of the RFA for specifics.

No more than 20% of the total award may be used for data collection, performance measurement, and performance assessment.

Tips for Managing the Grant Writing Process

- **Begin organizing and preparing an outline**
 - Match required information in each section
 - Don't hesitate to repeat information in different sections if asked
 - Pay close attention to the points give to each section of the review criteria

Section A: Population of Focus and Statement of Need (15 Points)

“Why do you need this support in your state/tribe/organization?”

- Identify target population and rationale. Include the prevalence of suicidal behavior and use local data when possible to describe the need.
- Describe the pattern of adult suicide, including service gaps in the health system/s, and document the extent of the need for restructured, comprehensive care.
- Discuss current limitations of suicide and suicide attempt data collection within target healthcare system/s.

Section B: Proposed Implementation Approach (30 Points)

“How will you do what you propose to do?”

- Explain purpose, rationale, and how you will reach your goals. How will meeting these goals will have meaningful results for your healthcare system/s?
- What will your plan look like (realistic 5 year timeline)?
- Discuss how each of the seven elements of the Zero Suicide model will be embedded within your health system/s.
- Describe your safety planning process, follow-up strategy and plan for reducing access to lethal means.
- How will you ensure all individuals are screened, assessed, followed and reassessed throughout care?
- How will you work with identified populations, such as veterans, individuals with serious mental illness, etc.?
- How will you integrate survivors of suicide attempts and suicide loss into your project?

Section C: Proposed Evidence-Based Services/Practices (25 Points)

“What are you going to do?”

- Explain how your choice of an EBP or practice for each of the seven domains of Zero Suicide will transform your health system and address disparities in service access, use, and outcomes
- How will you train your workforce in suicide prevention EBP relevant to their position, including identification, assessment, management, treatment, and evaluation of individuals throughout the overall process?
- How will your grant program incorporate efforts to reduce access to lethal means for individuals with identified suicide risk?
- How will you monitor the delivery of proposed EBP and ensure fidelity and impact?

Section D: Staff and Organizational Experience (10 Points)

“Why is your state/tribe/healthcare system best suited to do Zero Suicide?”

- Discuss the capability and experience with similar projects in size and scope and show ability to influence selected state, local and/or tribal healthcare organizations
- List staff positions (roles, qualifications, level of effort) including project director and evaluator. Demonstrate successful project implementation for the level of effort budgeted for the Project Director and Evaluator.
- Discuss how key staff members have both experience in suicide prevention and working with health systems

Section E: Data Collection and Performance Measurement (20 Points)

- Document your ability to collect the required data.
- Describe your plan for assessing the impact of the project on suicidal behavior of individuals within your health system.
- Describe the quality improvement process that will be used to track whether your performance measures and objectives are being met, and how these data will inform the ongoing implementation of the project.
- Discuss how you will ensure fidelity to the Zero Suicide model over time and how you will address barriers to successful implementation if they occur.

SAMHSA and SPRC Resources

- Resources for grant writing –
<http://beta.samhsa.gov/grants/applying>
- SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) <http://www.nrepp.samhsa.gov>
- State pages (including data pages)
<http://www.sprc.org/states>
- SPRC library http://www.sprc.org/library_resources/listing

Other Important Resources

- National Action Alliance for Suicide Prevention's Zero Suicide in Health and Behavioral Health Care
<http://zerosuicide.sprc.org/>
- 2012 National Strategy for Suicide Prevention
<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>

IMPORTANT TIP:

Submitting Your Application in Grants.gov

- **DO NOT PUT OFF SUBMITTING YOUR ELECTRONIC SUBMISSION UNTIL July 18! (THE DUE DATE)**
 - *There have been grant applicants who experienced unexpected technical glitches with their submission at the last minute. That resulted in their missing the grants.gov deadline and their application was not reviewed. **PLEASE DO NOT PUT YOURSELF IN THIS POSITION!***
- *We suggest you submit to grants.gov at least 3 days prior in order to troubleshoot and resolve any technical issues with grants.gov.*
 - *IT help available 24/7 at 1-800-518-GRANTS*

ERA System Requirements

- **All applicants must register with NIH's eRA Commons in order to submit an application. This process takes up to six weeks. If you believe you are interested in applying for this opportunity, you **MUST** start the registration process immediately. Do not wait to start this process. SAMHSA will not be able to accept applications from applicants that do not complete the registration process. No exceptions will be made.**
- Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements). Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

*** See FOA document part 2 for more info**

*Any questions about Application
and Submission?*

Thank you!

For Additional Questions

- Program related issues
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