

**2020-2-25\_Public Webinar\_Creating a Stronger Data Infrastructure  
for Suicide Prevention**

Speakers: Kristen Quinlan, Kirk Bol, and Jenna Heise

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>> KRISTEN QUINLAN: Alright. Let's get started. So, we're going to get started with just our funding and disclaimers slide. So, this just acknowledges our funding source and lets you all know that today we're not speaking on behalf of our funder although we do want to acknowledge their support in letting us do the important work that we'll be discussing today.

And before we begin, I also want to introduce you to the voices you'll be hearing today. As I mentioned, I'm Kristen Quinlan. I'm an epidemiologist with the Suicide Prevention Resource Center which is a national training and technical assistance center for suicide prevention.

With me is Kirk Bol who is the manager for the registries and vital statistics branch for Colorado's Center for Public Health and the Environment and today you're also going to hear from Jenna Heise who is the suicide prevention coordinator for the state of Texas.

Both of our speakers were very involved in drafting the recommendations that we're going to be discussing today and I'm very thankful for their help and input.

We also had some help from SAMHSA and I want to thank Deb Stone and Richard McKeen for their contributions, although they will not be speaking specifically on this webinar today.

Alright. So, in suicide prevention, there is a lot of focus on specific suicide prevention activities, training, media kits, policy change, that sort of thing. But as we implement our activities and as we make choices about our suicide prevention plans, we're supported by this broader infrastructure at the state level.

Today, I want to define this infrastructure and provide an overview of a report that we created on data infrastructure. It

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was written with the help of data experts like Jenna and Kirk and so after my overview, Jenna and Kirk are going to talk about how these data infrastructure recommendations have played out in practice in their states.

First, I want to give you some context. When we say suicide prevention infrastructure sort of globally, this is kind of what we mean, what we see here on this slide. What we mean is the state's foundation. So, this is all systems, organizations, and efforts that support good suicide prevention.

This is going to include your funding, your partners, capacity building opportunities, policies, anything that supports the planning, implementation, evaluation, and sustainability of our prevention efforts.

But as a field, we don't generally talk about this infrastructure and I think it is generally because we're too busy. We're responding to crises. We're saving lives. We're focusing a lot on individual, policy level, that sort of thing, and as a result we're kind of building infrastructure as we go without a lot of guidance and without really sharing information about what works regarding infrastructure with one another.

So, at SPRC, we wanted to stop and kind of look at the infrastructure elements that support effective, sustainable suicide prevention at the state level. So, to do that, we've created this state suicide prevention infrastructure report and as part of that, there is also a data infrastructure report and that is the piece we're going to be talking about today. But I want to cover this sort of global state suicide prevention infrastructure report first to kind of place that in a little bit of context.

So, when we wanted to create this state suicide infrastructure report, we looked at the literature. We convened an advisory panel. We formed work groups that focused on specific pieces of infrastructure, so things like data, funding, policy, programming. We asked state suicide prevention coordinators and target audiences for their feedback and some of you folks who provided us with some feedback might be here on the line today.

When we're finished, what we produced was a list of recommendations that fell under the framework that you see here

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in those circles. These are the six general categories of recommendations that kind of emerged from that process.

So, there are recommendations related to authorize which means that we need to designate some leadership, some authority around suicide prevention to make some decisions.

We were also - had recommendations regarding partners. These are specifics about who should be at the table.

We have recommendations related to a guide which means that we need a trained, competent workforce, and a way of educating the public.

Build means we need to assess our suicide prevention activities to make sure they cover the lifespan and cover the prevention continuum. Examine means that we have suicide prevention efforts that are data driven and well evaluated. Lead means we've funded a dedicated position to really support suicide prevention, to be like a suicide prevention coordinator in each state.

The full report is going to be on SPRC's website at SPRC dot ORG and at the end of the webinar, I'll be showing you how to access it. But first, you know, as I mentioned, part of this process, kind of part of this process, we developed a data infrastructure supplement.

We formed these work groups as we were going through the process of creating a broader infrastructure report and one of these work groups was a data work group and anybody who has worked with folks who work with data know that data folks are pretty detailed. So, when we got a bunch of data folks in the room to talk about infrastructure, that group generated some very specific, very detailed recommendations. So, we pulled them out for a special report. This is kind of a spin off supplement.

The data infrastructure recommendations are organized according to the categories that you see here listed on the slide. So, this is, you know, things like leadership, partnership, systems for identifying, analyzing, and using data, and there are some recommendations regarding connecting with state systems.

I'm not going to go over all of these because I think it is more useful for you to hear from folks who are implementing

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these on the ground who can talk about how the recommendations have really played out in their state, some of the things that they were able to really take advantage of and kind of run with.

So, I'm going to turn it over to Kirk Bol who is with Colorado.

>> KIRK BOL: Great. Well, thanks so much, Kristen, and thank you all for the opportunity to share Colorado's experience with developing a strong suicide related data infrastructure in support of our suicide prevention efforts here at state and local levels but also as we play a role in our national efforts.

So, again, my name is Kirk Bol and among my roles here at the state health department here in Colorado is to oversee some of the key data collection, analysis, and dissemination or public health surveillance around suicide data and that includes overseeing our vital statistics data analysis, so those data collected through vital records like death certificates. And then also through some enhanced mortality surveillance activities such as our participation in the National Violent Death Reporting System as well as the State Unintentional Drug Overdose Reporting System, respectively the NVDRS and SUDORS programs which I'll talk a little bit about as part of my presentation today.

But before digging into the detail, I just want to preface this by saying that we continue to be on a journey to build, innovate, and participate in Colorado's growing community of suicide prevention practice and indeed, what we've done over the last few years regarding data infrastructure is not the end of the journey but a series of first steps to ensure that we have a robust suicide prevention - suicide prevention data infrastructure in place and that we're responsive to the needs here in Colorado.

So, as Kristen mentioned, there are six key data recommendations and going out of order, I'll be presenting on three of them while my esteemed colleagues in Texas will be presenting on the other three. In fact, I will be deferred to my co-presenter here to talk a little bit about recommendations one, two, and six, so those concerning leadership, partnership, and creating connections for synthesizing and applying the data that we collect.

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The focus of my comments will be on the recommendations 2, 3, and 5, focusing on data sources, data analysis, use, and dissemination.

So, I do have some placeholder slides in here just for those first couple of recommendations that will be deferring to other peers to present on. Again, core leadership, information, as well as establishing partnerships and coalitions. So, I'm going to skip over to establishing a system for identifying data sources and sharing data which is the official recommendation.

So, what does that mean? So, that particular recommendation is comprised of a variety of key characteristics and steps, including identifying and ensuring locally available data is - is available, creating connections with underrepresented communities, and ensuring that those folks are at the table and informing our data collection and analysis activities.

We want to have key - we want to have steps in place to address data gaps that exist. We want to be able to acknowledge them and work towards filling those gaps. We want to consider locally collected data where what we can collect at the state level is often robust and population based. It may not always be as specific or as timely as is necessary for some local suicide prevention efforts, so where our data infrastructure can support locally collected data and similar efforts, that's a critical element.

Part of collecting and maintaining and data infrastructure is having that state level commitment to ensuring that we have such data infrastructure in place and that includes not only that political commitment, that organizational commitment, but that we have both technical and legal infrastructure in place to support that.

So, these are kind of the main subheadings for this recommendation, so now I want to get into a little bit about how Colorado views that and how we have implemented that here.

So, part of achieving any success in - towards this recommendation are a couple of frameworks that we keep in mind and that we recommend others consider as well, the first being data relevant to that iceberg of suicide if you will, ensuring collection and availability to all aspects of suicide.

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Of course, suicide deaths are the smallest number overall of our deaths in that final outcome in this case, but we also want to make sure that we capture information on nonfatal suicide related events due to hospitalizations and emergency departments as well as information about suicide risk in our population and so, outlying that here are a couple of key programs and key - a few key data sources related to those. So, for suicide deaths, we rely heavily on our state vital records office and the vital stats program that I manage and our analysis of those deaths. Again, through the national and state violent death reporting system here in Colorado, we utilize enhanced information from our coroner's offices and law enforcement reports to paint a more complete picture about the circumstances and toxicology around those suicide deaths so that we can understand better some of those upstream factors and risks that might be amenable for prevention and intervention.

And partnering with that is newly implemented here in Colorado, is the State Unintentional Drug Overdose Reporting System or SUDORS. So, while focusing on not suicide related overdoses but unintentional overdoses, we do know that there is a natural nexus between overdoses as an outcome and its entirety and a need to address both accidental and suicide related overdoses.

Again, with regard to hospitalizations, this involves making sure you have good relationships with the source of your administrative claims data in the state. In Colorado's case, it's the Colorado Hospital Association, an external nonprofit member organization who manages the discharge data program for the state for both hospital discharge as well as emergency department visit data.

And so, we utilize those data in our office as well to paint the picture of - to the best we can, of nonfatal suicide related events.

Tied in with hospitalization data, and I'll get into this as well a little bit more, are some of the potential for data linkages for such things as hospitalizations or emergency department visits seen within a given healthcare system and being amenable to helping them link those two state mortality data or other data sources so we can understand some of those downstream events and understand fatal outcomes among people seen within a hospital setting.

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So, I will get into a bit more on data linkages here in a bit. And then again, emergency department visit data. Colorado is kind of new into this realm of utilizing syndromic surveillance data for some more rapid data collection around suspected suicide related emergency department visits and trying to incorporate what we can find with rapidly collected data. While it suffers from a lack of specificity potentially, we might have to - we do want to understand what is going on on a day to day basis with that. And then again with suicide risk, Colorado has a number of health related surveys such as the Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, and others to try and assess potential suicide risk in our various populations, both adult and youth, through asking questions around prior suicide attempts, suicide ideation, and general mental and physical health issues that we know are associated potentially with suicide risk.

So, that kind of paints a picture of data that we would consider for analysis and do use for analysis. Once we actually acquire some of these data, we also want to be mindful of what it means to have data at state and local levels and identifying appropriate applications of each. So, a lot of our analyses focus at analyzing data at a state level, maximizing our ability to stratify by risk factors and demographic characteristics where there might not be at a local level, a lot of events, but which at the state level, we can develop some statistical power to understand better, those risks and connect those with state-wide prevention efforts. But we can't discount the need for county and local level data where we can look at county and even sub county level data at a community with appropriate geographic definitions like county, census tract, and others, and that also affords the opportunity to link to census data to understand the characteristics of our populations and also to be able to maybe focus some of our prevention efforts.

And then also at the provider level as well, as I mentioned, working with physician groups, working with healthcare system, working with hospitals and payers, understanding suicide related outcomes among populations that they serve and what opportunities exist within a healthcare delivery environment for intervention and prevention with suicide.

So, again, to accomplish this, there are a lot of considerations both quantitative and administrative, all of which we need to address in order to maximize data availability and usefulness for suicide prevention. I alluded earlier to

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underrepresented populations and that requires engaging both prevention partners and these communities to make sure they are at the table and share with us what their needs are and identify opportunities to collect, analyze, and share data products that are meaningful there.

Provisional data, reflecting the need for timely yet reliable data. Having information at an annual level is no longer good enough for a lot of our public health prevention efforts, so identifying techniques from a data standpoint and statistical standpoint that allows for more timely yet still reliable information to be able to respond quickly to events and emerging issues is going to be critical.

One of the challenges, of course, is sharing data at various levels, whether identified or de-identified, and then also making sure that legal permissions and data sharing agreements are implemented for that, and that starts with having commitments to share those data and not using the challenges of creating data sharing agreements and working through legal review approvals and even HIPAA and privacy-related stuff and dealing with healthcare data. Not - not using those challenges as an excuse not to pursue that.

Then of course, data linking. When all of these things are in place, we acknowledge that no one data set can give us all of the information. When we link these data sets together, we can often get a great deal of synergy with that in support of our prevention efforts.

So, that is kind of a whirlwind overview of how we - some frameworks in which we have looked at data sources and then of course once we have data, we have to do something with that and establishing a system for analyzing data is a critical next step and in fact represents a series of steps we need to take to ensure suicide prevention efforts have the information they need derived from the data sources we just discussed.

So, that includes maintaining staff, both physical and personnel capacity and technical capacity for targeted analysis, the budgetary support, quality assurance that data remain timely, that they remain complete, that they remain accurate for what we're trying to collect while still acknowledging those limitations and those data gaps that we want to continue to work towards addressing.



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So, a quick overview of how we're organized here at our state health department within our Center for Health and Environmental Data. Not dissimilar from Centers for Health Statistics and other state agencies, we have our health statistics and environmental branch which houses a variety of programs, including our vital statistics program that I oversee, some chronic disease epi, maternal and child health epi, and our survey research program.

Included in these, based on the red boxes, are some of the most relevant to this conversation, our vital statistics programs where we oversee a series of programs that incorporate some GIS capacity, some publications and information dissemination capacity, data analysis, supporting particularly data linkages, but then also our mortality surveillance unit which houses both our NVDRS and our SUDORS capacity for Colorado.

So, we're fortunate to be concentrated as data collection, analysis, dissemination programs in one area where we also partner closely with those groups that oversee our data collection for BRFSS, for YRBSS, and some of the supplemental data that we use.

And of course, this is just in the area that I work in directly but we also have key partners that make up our data infrastructure as well in our Child Fatality Prevention System, our Child Fatality Review Group, who I know there are folks there on the call here today as well, and glad to be able to partner with them on their efforts as well as Colorado's Maternal Mortality Review Program.

So, there is indeed a network of data related programs across our department that all have to work together to achieve our aims of ensuring that data are analyzed and disseminated in a meaningful way.

So, you know, within our programs, we attempt to focus on all key aspects of data analysis. While oversimplified in this little line, we must be able to achieve success in all aspects and engage in continuous improvement across the board in order to remain useful and relevant in support of suicide prevention.

That again runs the gamut from data collection and beating the bushes to get as much information as we can, all of the way back to getting information and feedback from users of our data

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products that we might create, whether that is a report that we might publish and release or the product of a big data linkage we might conduct for our partners to understand outcomes there.

So, there are a lot of steps to take in the meantime and we want to ensure excellence is achieved in all of those.

So, one of the - of course, the key objective to this work is not only to describe suicide at a large scale in Colorado but be able to focus on specific and often underserved populations within our state. Included in these are various categories within the population of working age men in Colorado in which we continue to see the highest numbers and rates of suicide death.

Presented here is just a screenshot from Colorado's Man Therapy site that others have used as well that provides resources for you know, principally directed towards men but also their families and their communities to understand the risks of suicide within working age male populations.

We also focus through data analysis, publications, research, and data linkages in a variety of other areas, including youth suicide, suicide among our LGBTQ population, veterans and first responders, homeless, older adults. These are all populations in which we have done some targeted analyses and publication of reports on it in the recent couple of years and not only have they resulted in publication of stats that allowed us to learn something new about the occurrence and risks of suicide, but it also opened doors to understanding who other key suicide prevention partners are. They're not always the ones we think about up front as part of putting these things together, but also after the fact and their response to our reports and application of that information.

That kind of leads to establishing a system for using data which has some key subcomponents, including a regular reporting to our key suicide prevention partners, being responsive to inquiries such as data requests and communicate local level data, maintain a capacity to address emerging questions through additional data collection and analysis, incorporating best practices for communicating and presenting data and again, combining multiple data sources to tell a more complete story.

So, we achieve that through a multi-pronged approach of data dissemination and ensuring information is presented in a useful form and getting into the hands of the people who can use it

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most, including through printed and online reports, ensuring that we're able to present data through our suicide data dashboard that we maintain, responding actively to data requests, and participating in original research where we can.

Given the time constraints, I don't want to dwell too much on any specific product but I would encourage you to check out some of our products that you can find easily online through Googling Colorado Suicide Prevention Programs where we have links to a variety of reports demonstrating here with some of our targeted populations, some of our audiences for key dissemination practices, snapshot of our suicide data dashboard and interactive effort to make sure data are available to folks. And responding to data requests from everybody from the general public, our policymakers for the state, our suicide prevention partners, researchers, and others.

So, while not a primary agenda for our state health department, we've had the opportunity to perform and conduct and publish research and participate in some research here in Colorado, applying some enhanced analytic techniques to some complex data to understand the nuances of suicide in some key populations.

So, again, I'll be turning it over to our colleagues in Texas to talk a little bit about how these data are used and connected to suicide prevention efforts. But before that, I'm going to skip over that and just say thanks for the opportunity to present to the group today. I welcome any questions at the appropriate time and want to make sure that you have some resources here where you can find our data products and see some of this work in action in Colorado. So, I encourage you to acquire these slides at your convenience and check some of this out. So, thanks for all of that and I'll turn it back over to Kristen.

>> KRISTEN QUINLAN: great. Thanks so much, Kirk. Really appreciate it. So, what you're going to see pop up now is a quick poll that is going to give you a couple of choices on how you might use the information that was just presented. You're welcome to check all that apply and as you're doing that, I'm going to read through a couple of questions that did come in for Kirk as he was presenting.

Kirk, one of the things that came up for us was regarding local level data collection efforts. Folks seem to be quite

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interested in that, particularly with regard to overdose data in communities. Can you tell us a little bit more about how that works at a local level?

>> KIRK BOL: Sure. So, that can take a variety of forms and admittedly, you know, there is not specific standards around that. Some examples around that might be in response to a series of suicides among youth in one of our counties in Colorado, rallying those folks who might have information about that to form some sort of even ad-hoc or temporary review committee to look at the information from those suicide deaths made up of representatives such as the coroner's team who investigates those deaths or suicide prevention partners at state and local level, school officials there.

So, while not necessarily collecting a lot of new discreet data, but having a conversation about the available information for deaths that might have occurred or even non-fatal events that folks have recognized through healthcare interactions and what not.

So, that is an example of convening a review team and trying to synthesize conclusions from even qualitative reviews of some of those events, but also particularly health surveys. And things around suicide ideation, especially among youth where survey - health surveys are often limited by sample size and inability to be able to be aggregated and presented at the community level where those gaps occur, conducting more focused health surveys say, among school-based populations or even other populations within a community, within a county to try and gather maybe similar information as a state-wide survey so it can be compared, but with sufficient statistical power and sample size to be able to conclude something there.

So, those are, you know, kind of abstract and vague examples, perhaps, but opportunities for some of the local level data collection there.

>> KRISTEN QUINLAN: I imagine that this question is kind of similar because it probably emerges from some of the local level data. But I have folks wondering if you were able to put a system in place for more real-time reporting of suicide deaths specifically so you can target post-vention efforts.

>> KIRK BOL: In Colorado, we don't have that at this point in time, not at a state-wide level. So, we have seen where there

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might be multiple suicide deaths, again, among youth that will rally members of the community to behind those conversations.

We don't, unfortunately though, have a mechanism for real-time, you know, if you were to go looking at suicide clusters, if you will, on a real-time basis. But that is an aspect of this infrastructure that we need to learn how to improve a little bit better. There are definite limitations with things like death certificate registration and even coroner reporting and the timeliness of that due to no fault of coroner reporting but just the complexity of some of these events and that is where we're starting to look also at things like syndromic surveillance and rapid reporting of emergency department visits, as that can paint a broader picture too, not just of suicide deaths but of those who are seen in the healthcare setting in some form which are generally at higher quantities, particularly if not to detect somebody at risk up front, but to understand what the downstream effects are in response to that when a suicide does occur in a community and the effect it has on others.

>> KRISTEN QUINLAN: Great. And one more quick question for you. You spoke a lot about data linkages and I had a question come in about telling us more particularly about data linkages as it relates to hospital discharge data. So, when you're talking about linkages at that level, you know, what are you referring to and how do you go about that?

>> KIRK BOL: Sure, sure. So, some of our key data linkages have not been necessarily through population-based data such as the state-wide hospital discharge data sets and there are some even limitations to what we can do there. But in fact, we have had great success working with some of our key healthcare systems in the state, whether it is Denver Public Health main county hospital for the city and county of Denver or Kaiser Permanente of Colorado or a couple of other health systems in which they understand the population they serve but not necessarily suicide and other mortality outcomes from there.

So, they understand the services provided but with the data linkage, they can understand who among their patient population might have died from suicide or died from other causes related to that such as overdose or other types of chronic disease or causes that might be related to self-injury of some form.

So, they can then understand better within their population, what is going on, and be able to act on that a little bit more.

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And that is one of the key components to Zero Suicide effort, invite people to explore that and understanding the outcomes among a, you know, a unique patient population and responding to that.

So, it's not just linking available data but sometimes again, making sure we're available when individual organizations want to be able to do some linkages as well.

>> KRISTEN QUINLAN: Great. Thank you. So, we had a couple more questions come in. We'll try to hold those until the end if we get a chance. I want to give Jenna a chance to present as well.

In the meantime, you know, really appreciate your participation in the poll. It looks like a lot of folks are planning on using this information to you know, establish some new systems for identifying new data sources. Kirk gave us some really good ideas about where to start there.

So, next I want to turn it over to Jenna to talk about the Texas experience.

>> JENNA HEISE: Thank you. Hi, everybody. I'm so grateful to be here and Kirk, thank you so much. I learn something from you every time that you share with us so thank you.

I am the State Suicide Prevention Coordinator for the Texas - for the state of Texas. We're located here in Austin, Texas, and I am now the team lead, which I am very happy to be able to say, for our wonderful team of suicide prevention experts that we have been able to gather together.

We are housed here in the Texas Health and Human Services Commission and we are in the Office of Mental Health Coordination. So, very happy to be with you.

Excuse me. So, we'll just dive right in. I'm going to get my little - hold on. Sorry. There we go. That's up to me. Yeah.

So, as Kirk mentioned, I'll be talking about the three recommendations, excuse me, 1, 3, and 6 respectively. So, those bullets actually represent 1, 3, and 6.

And as was mentioned before, really, that opportunity to create that buy-in. This for me really harkens back, and this is

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what I love about how SPRC has been able to bring all of this together. Some of you are doing this work in a lot of different ways and if you do this work as it relates to the National Strategy for Suicide Prevention and/or Zero Suicide, you will be able to see how these elements really line up in so many ways.

And of course, one of the main recommendations - I mean, going over the National Strategy for Suicide Prevention and the National Society for Veteran Suicide Prevention is around making this a core priority for healthcare systems.

And so, what's really nice is we see this again, this buy-in of leadership and how really important this is. So, not only any suicide prevention efforts in health and behavioral healthcare, from national strategy, we have really been able to drill down more over the last several years since 2012, looking at you know, those systems within healthcare and with the Zero Suicide Framework. And now, you know, so much needed within our state systems themselves and then you know, the privilege of working on this with this great team to look at really what is the data infrastructure that is needed.

So, excuse me. I'm going to talk about that. And then of course, we would be nowhere without our partners and these wonderful coalitions that help to hold up the work that we do at the state level. So, I'll be talking about that for a moment and then kind of how we collate this, analyze it, and then from a state system perspective, how do we utilize this and make this meaningful and relative for everybody who really needs to look and touch this data?

So, excuse me. I'll move through this. All of this is basically from my perspective, of course, at a state level, trying to implement the state infrastructure from these different elements.

So, if we hone in here on recommendation one - excuse me - I have kind of put the national recommendations over on the left and if you read the report, you get a chance to kind of look at - what's really nice, one of the things that we're being able to really define now for the first time in the field like with the suicide care recommendations that came out recently, you know, this minimum standard of care which it's kind of ludicrous in a sense that it's 2020 and we're just doing that, but also, hey, we're doing it. So, we have this idea for state suicide

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prevention data infrastructure that is just sort of the minimum required but we really want to all start having in place.

And then we had this idea also of hey, you know, some of us are doing great jobs in other places and some of us are, you know, stronger in others. So, we had this idea of what was kind of the minimum standard of what you really had to do to stand up data infrastructure in the State Suicide Prevention System. And then what would be the sort of more robust look at you know, really moving towards those very sophisticated systems?

And so, you know, that is all identified there. So, I just pulled out the minimum standards over here. So, the next couple slides, I will show those and then - as labeled in the boxes - and then in the other side, I tried to just pull out a couple of examples from our textbook efforts - excuse me - within our infrastructure and our implementation and what we're trying to do to support them.

So - excuse me. Take a look over here at this. You can read the actual ones on the left-hand side that are from the document itself with the data supplement and they are quoted from that resource. And then over here on the right, you'll see these different pieces here.

So, if we kind of look at - we have what we call the Texas Administrative Code. Everybody has whatever their legislatively mandated - excuse me - statutes are. So, we are very fortunate that for many years now, we have had an actual statute that supports Texas Suicide Prevention Office, they call.

So, my position has been a statute for many years and so that is really wonderful because as was said, we're really not having to worry about is this going away or not? You know, they could always change the statute but at this point, that is really wonderful.

So, the agency supports that position and so you know, you've kind of got that stability which is really key. So, that is a really nice thing that we are able to launch off of there.

And then what has been really nice is oh, you know, we talked a lot on these types of things before about, you know, you always see in these presentations, raise your hand if you're a data geek or data geek, you know? And then there are always the



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people that like, reluctantly, like, well, I had to. It's a part of my job.

But you know, I'm here to just kind of say hey, you know, you can do this either way and we can all work together because this has just really grown to be so much a part of my heart to this work and all of us to do this. Of course, we all see this. If it's not our, you know, cup of tea, then there is always somebody around who it is theirs and we've just got to grasp onto them. With all of these different backgrounds, we can all come together - excuse me - and this supplement is just such an excellent resource now for us to really look at those people that it really isn't their thing.

For a lot of us, it has just been this on the job training, you know? Here I stand ten years later and I can spout off all of this stuff - excuse me - that of course I didn't know half of it when I got in here. Just my background as a counselor.

So, then we move in and it was just so exciting because of being apart and having an opportunity to be part of the whole development from the beginning, I had this language and they kept talking about it and so having, you know, these kinds of resources at our disposal and this sort of language and things put together in these sorts of ways, I would be able to go to leadership or you know, when I had that one-minute elevator speech prepared and the right person was in the right room with me, then I would be able to have this and then we were able to get a position now that is devoted fulltime to this in our office.

And she is actually on the line today, Jennifer Haussler Garing. She did the Youth Risk Behavior Survey for thirteen years at our Department of State Health Services before this position. She is just really amazing. Very excited to have our own epidemiologist and so, that is a major win for us in Texas that we wouldn't have had without this.

I think the other key to really point out here is that the wisdom of this whole approach which is really utilizing so many different peoples' skillsets and so the advisory committee you'll see on these recommendations is made up of so many different types of people with different types of backgrounds and experiences.

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You have, you know, the PDP of SAMHSA and HRSA and lots of different agencies like that coming together. The American Foundation for Suicide Prevention, SPRC, the National Council on Behavioral Health, then there is the VA. You know, I could go on and on. NASMHPD, the National Association for Mental Health Directors, and injury control centers and things like that.

So, what was nice was this message was coming across from all of these different platforms, and so that also gave it a lot of strength. We had senators in congress and representatives on there as well, some clout on some of those types of things as well. So, that is another thing that we can take back as we're looking towards, you know, creating the kind of leadership and the buy-in. It's like hey, these are the types of people that really are making this happening.

Excuse me.

So, I'll just go to the next thing here. So, I think that's important to get in front of our leadership, we're wanting to try to enhance efforts or build efforts.

So, the same thing. We're looking at the left side here. These are the recommendations that we have and it's also important. Of course, many of you probably already have this but you know, sometimes we have the data champion outside of the state sort of infrastructure or agency systems or sometimes they are within. So, of course, you know, we want that broader scope of both working together. You know, sometimes there are histories there but to the extent that we can, get people involved and come together. That is really key and really important, so that goes to that partnership piece but also, you know, again, always putting the goal and the mission to save lives first and most important.

So, whatever we have to do to iron that stuff out as leaders, to really bridge that gap and make sure that we have those data champions in all of those different places is so key.

And so, we've been able to do that at the community level and the local level through our partnerships there with our community mental health systems which we have purview over. So, we have state suicide prevention courts made up of our local community mental - community suicide prevention coordinators at each of our suicide prevention - oh my god. Let me take a break there.

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We have, at each of our local mental health authorities, we have thirty-nine across the state of Texas which are community mental health centers, we have suicide prevention coordinators. So, we have thirty-nine across the state that I work with in my team and we do you know, a sharing of ideas, partnership, and ultimately they are providers of our contracts with them. So, we are able to build in some things for them around these types of things. We actually have some data pieces in there for them.

Excuse me.

But again, it is about that local leadership and them being our local arm. So, that is really a beautiful thing. And then they go out and they work with the community members around all of this and then we're able to equip them with what they need. Excuse me.

So, we have state-wide strategic plans that we're able to pull together. We have a public and private partnership that we're able to pull together. And there is sort of the other - they are the community suicide prevention piece of this and then we're like the state suicide prevention piece and both of those arms have to be together and working together to make this really happen.

And let's go on to the next slide here.

Oh, one thing I do want to mention about the data dashboard we're creating, that is another really key place that we can explore leadership around what we're doing and I'll give some examples later if we have time or you can get my slide set here. Excuse me. Wanting to drink here.

So, this is alluding to what I was talking about earlier, some of the very robust data infrastructure ideas that we were talking about. They are so important.

So, as I mentioned, having that role, that person within the office, like I said, Jennifer Haussler Garing, and all of the things that she has been able to do and bring to the team is just really fantastic. Excuse me.

Having somebody with that public health lens inside of the behavioral health system is really great because it widens the look and the approach and I also want to say that it has to do

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with number one and number six because you know, we're really looking at her whole position title is about outcomes and policies as well because with that data lens, we could be pulling all of that information together for different types of initiatives that come across our desk but you know, this person is really going to be able to look at our full - we stand back and we look at as a whole, what are we really trying to accomplish, you know, as a whole, and then how do these different grants and these different initiatives and these different implementation things that we get handed, how do those all work together and what are the key data points and outcomes that you know, can be threaded across that board? What are the key policies and protocols that we really need for that? Excuse me.

So, this is just our fully improved suicide prevention team. And this spot - don't get me started on this slide. It's really wonderful. The main point is that within our entire agency, this truly is about the leadership. It is also about - this is kind of my first look into the last slide, into part - excuse me - six, about the partnership and about the data dissemination because we have basically a billion and a half dollars for the business within our agency around all of these services.

So, these are all of the different departments that are working on suicide prevention and you can see that fifth little box is all about the data analysis. My team is working with all of these different parts, so it is very exciting, the infrastructure we have been able to develop and grow.

And then this last piece here, with the formal recommendations there I'll talk about and I'll mention here. I think one of the key pieces with this is remembering our survivors of suicide, loss, and suicide attempts. We have that as a key piece of our state team. Always keeping that lens in everything that we do and I think that is also extremely important when we talk about our coalitions and our partnerships and all of the different things that we bring together at the table.

So, if you look at this list of things here that I have written out as Texas examples, you can see that that is definitely a key part of that.

So, the rest of these are examples just on here of some of the data we have been able to pull and collect. So, this will be

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available to you. This is some legislation and again, these are just sound clips, thumbnails, data pieces that we have been able to put into data dashboards that we're creating, into newsletters and media clips and the blogs and to newsletters and we've been able to show all of these different pieces.

I'm going through them very quickly because they are not meant for you to really see more as to understand that we're able to take all of these and utilize all of these different things coming into us and really make them come alive and make all of these pieces work together and I think that is what is really exciting about having the type of infrastructure developed if we're able to pull all of this together and look at how it can be helpful to all, you know, to all of the different high risk groups that we serve, all of the different stakeholders that we serve, you know, from schools to higher ed, excuse me, all of the way to our higher leaders in administration and legislators down to all of our wonderful community partners.

And so, by having this type of thing, making sure that we're looking at the diversity of our culture and what their needs are and being culturally competent in all of these different ways, these are some of the newest resources and developments that we've pulled together to try and answer that call. Excuse me.

So, that just leaves me with a big thank you. That's Jennifer's information there who is our, like I said, our newest team lead. And me and Matt and that is me and thank you so much.

>> KRISTEN QUINLAN: Perfect. So, I'm actually going to pull up a poll real quick. So, again, you can have an opportunity to think through how some of the information that Jenna presented today might be useful for you as you kind of think through some of the recommendations that she covered, particularly with regard to partnerships, leadership, and using state systems.

So, we're going to pull that up real quick.

Again, how might you use the information that was just presented to build leadership buy-in, to establish partnerships?

If you have had a question that has come in and we have not answered it, we are you know, kind of running a little bit out of time so what we'll do is we'll reach out to you separately to make sure that those questions will be answered.

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Julie has been typing very helpfully over in the chat too, so you will see some things pop up in the chat that kind of give you some information about the work that we have done as well and where you can find various things that have been mentioned by our speakers.

So, I'm seeing folks responding to the poll. Appreciate that. A lot of people thinking about that leadership buy-in which is really important from what Jenna had highlighted. She had this opportunity, this chance opportunity to really get in front of the right people with the right recommendations and make the case for higher critical support staff for her - for her efforts. So, that epidemiologist who is now on her team has been a huge win for Texas. So, I appreciate that and I'm glad to see it was helpful for other folks as well.

So, not seeing any - oh, one additional question came in, so question about EMS data. So, for example, if we're thinking about syndromic surveillance data that we're collecting from the emergency departments, how might we kind of think about that data in comparison to data that we're receiving for emergency transport systems, that sort of thing?

So, Jenna or Kirk. I don't know, folks, if either of you can respond to that if you have a minute or two for that?

>> KIRK BOL: This is Kirk. I'll speak briefly to it on my end, for Colorado's end. So, we have not utilized EMS data so much for - as part of our suicide suite of suicide data products as of yet, in part because of some of the complexities of the legal access to those data, things like that.

Where we do have robust EMS - sorry - emergency department data and mortality data, we can begin to triangulate some of that as well but we have not used EMS data quite yet for that.

Syndromic would be - syndromic surveillance data which is really rapid reporting by emergency departments to our syndromic surveillance system here in the state and really based on chief complaint type information is going to be some of our least specific but most timely information where we can use information from that to potentially link to pre-hospital care such as EMS data as well as subsequent discharge data. Understanding what happens after the fact is something we would like to work towards for sure.

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>> JENNA HEISE: This is Jenna. We are utilizing that data to some extent in our epidemiology injury prevention branch and we have even talked about writing a new rule because you know, they have near drownings as a part of that, that can be logged in when EMS shows up at the site. We've talked about creating a rule for near suicide. So, as far as I know, nobody else has done that in the US because I talked to people. But if you all know people that have at this point, because this is like a year and a half ago. Anyway, we don't have a lot of time. But yes. We're using that.

>> KRISTEN QUINLAN: Great. Thanks to you both. We're going to pull the poll down for now and just run through our final couple of slides to give you some resources on where you can find some of the recommendations that we discussed today.

So, first the kind of - that broader overview. I mentioned that the data infrastructure report is a supplement. It is part of a broader state infrastructure tool that can be found on SPRC's website. So, if you go to SPRC dot ORG backslash state infrastructure backslash tools, you can get directly to that site. So, that is going to give you space to download that broader infrastructure report as well as the data infrastructure report specifically so you can see the recommendations one through six that Kirk and Jenna ran through for us today.

So, again, there is a couple of things coming up in our tools section that you will be able to see both now and coming up in the future. You can see the data infrastructure recommendation report like I mentioned but we also have a series of state infrastructure success stories. These are states that we've identified that are implementing some of the recommendations that came through on those infrastructure reports, doing a really great job of it. They provide some nice lessons learned so you can figure out how you might apply those lessons in your own state as well.

There is a nice getting started guide to the infrastructure report as well as some timelines, development tools, essential elements tools, some things that really guide you through and walk you through sort of step by step how to implement the recommendations that have been promoted through these products. So, those are some really nice tools for you as well.

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As I mentioned, if you put a question in the chat that we did not get a chance to get ahold - have a chance to address today, we'll make sure we get ahold of you and answer that question for you.

But then I would like to thank you and also just a big thank you to Kirk and Jenna for their presentations today. Very, very informative, and I really appreciate the time and effort that went into creating those presentations and I look forward to speaking with you on future webinars.

Again, please check out that SPRC site for those infrastructure reports.

Thanks so much.