Zero Suicide Initiative Data Collection Plan Worksheet

This document outlines reporting requirements for your Annual Progress Report and is intended to assist you in developing a data-driven, quality improvement approach to suicide care. It reflects critical measurements focused on maintaining fidelity to a comprehensive suicide care model over time.

These reporting requirements should be included in your local data collection plan, a requirement written in the Programmatic Terms and Conditions in year one of the Notice of Award. It is highly recommended that you work seek technical assistance to develop a concrete local data collection plan to support the reporting requirements. A well thought out plan will ensure data is collected efficiently and systematically.

Below is a template of a local data collection plan that ALL projects are required to address and you are expected to use to meet the requirement for this section of NOFO Application. You may also add other data that you plan to collect and monitor during your project but it is not required.

The reporting period will be from **April 1, 2022 to March 31, 2023** as well as subsequent project periods thereafter.

Zero Suicide Culturally-Informed

Initiative: April 1, 2022 – March 31, 2023

Protect Year 1 Outcome Measures

Goal	Objective(s)	Measures	How Will Measures Be Collected/ Documented?	Who Will Collect/ Document Measures?	When will Measures be Collected/ Documented
1) A leadership-driven, safety-oriented culture committed to reducing suicide among people under care	a. Establish local ZS Oversight and Succession Team b. Establish community advisory committee to include providers, paraprofessionals, community partners, etc. c. Develop local level policies and procedures for the comprehensive, culturally - informed suicide care d. Conduct Organization Self Study e. Conduct Workforce Survey f. Develop Implementation/ Work Plan	a. 1. Roster of ZS OST 2. Record of OST Mtgs. b. 1. Roster of ZS AC 2. Record of ZS AC Mtgs. c. Approved local P & P in place d. Results from baseline OST e. Results from baseline WFS f. Approved I/WP			
2) A competent, confident, and caring workforce;	a. Report of staff trained in EBP for Screening b. Report of staff trained in EBP for Assessment c. Report of staff trained in EBP for treatment of suicide risk	a. Total # of staff trained in EBP for Screening/ Total # of staff b. Total # of staff trained in EBP for Assessment/Total # of staff c. Total # of staff trained in EBP for Treatment/Total # of staff			

	d. Report of staff that report feeling competent to deliver suicide care e. Percent of staff that report feeling confident to deliver suicide care	d. Total # of staff that report feeling competent to deliver SC/ Total # of staff e. Number of staff that report feeling confident to deliver SC/ Total # of staff			
3) Universal Identification of those at risk for suicide	a. The percentage of patients receiving "universal" suicide risk screening b. The percentage of patients receiving positive suicide risk screening referred for assessment	a. Number of patients who received a suicide screening during the reporting period/ Number of patients enrolled b. Number of patients who received a suicide screening duringthe reporting period/ Number of patients enrolled during the reporting period during thereporting period			
4) Collaborative engagement of those at risk for suicide care	a. The percentage of patients with a safety plan b. Percentage of patients with a counseled for resection of lethal means	a. Number of clients with a safety plan developed (same day as screening) during the reporting period/ Number of clients who screened and assessed positive for suicide risk during the reporting period b. Number of clients who screened and assessed positive for suicide risk and were counseled about lethal means (same day as screening) during the reporting period/ Number of clients who screened and assessed positive for suicide risk			
5) Evidence based, culturally informed treatment provided to all at risk for suicide	a. Percentage of staff utilizing EBP to provide treatment of suicide risk b. Percentage of staff incorporating culturally-informed practices and	a. Total number of utilizing EBP to provide treatment of suicide risk/ Total number of staff b. Total number of staff incorporating culturally-informed practices and			

	activities with EBP for suicide risk c. Types of culturally-informed practices and activities used	activities with EBP for suicide risk/ Total number of staff c. Catalogue of local "Culturally-Informed Practices and Activities (CIPAs)			
6) Continuous contact provided to those at risk for suicide during all transfers of care	a. Percentage of pts. with a suicide care management plan who missed a face-to-face appointment and who received contact within 8 hours of the appointment during the reporting period b. Percentage of pts. who had a hospitalization or emergency department visit who were contacted within 24 hours of discharge during the reporting period	a. Number of pts. with a suicide care management plan who missed a face-to-face appointment and who received contact within 8 hours of the appointment during the reporting period/Number of clients with a suicide care management plan who missed a face-to-face appointment during the reporting period b. Number of pts. who had a hospitalization or emergency department visit who were contacted within 24 hours of discharge during the reporting period/ Number of clients who had a hospitalization or emergency department visit during the reporting			
7) Continuous quality improvements in the care of those at risk for suicide informed by robust collection, analysis, and application	a. Establish a suicide data surveillance plan to collect, monitor, analyze and utilize to inform suicide care activities b. Establish local Quality Improvement Team (QIT) to guide the collection, reporting, and analysis if	a. Approved plan to implement/enhance data surveillance system to collect, monitor, analyze and utilize to inform suicide care activities b. 1. Roster of QIT 2. Record of QIT Mtgs.			