Screening
- Every patient, every visit
- High risk patients screened at every visit regardless of reason for visit

Tier 1
PHQ-9

Tier 2,3
SAFE-T

Assessment
- All positive patients assessed for suicide severity

Tier 1
CSSRS-t

Tier 2,3
CSSRS

Treat/Engage/Transfer
Stepped Care Model

All Tiers
* Safety Planning
* Lethal Means Counseling
* Rapid Referrals (Safe Transitions)
* Warm Handoffs

Clinical Implementation Team
- Conducts surveys for org. and staff
- Writes protocols for organization
- Provides oversight for clinical activities
- Coordinates trainings for clinical staff
- Works with Community Advisory Board
- Drives referral network
- Implements postvention plan for clinic
- Participates in postvention implementation in wider community

Community Advisory Board
- Builds referral network
- Implements postvention plan for wider community
- Receives feedback from community members
- Coordinates trainings for community members
- Referral members share data with each other for wraparound care
- Provides guidance for suicide reporting
- Delivers health messaging about suicide prevention to community

High risk patients are re-engaged at every visit
Safe Care Pathway is documented in EHR

Follow-Up
- Caring Contacts
- Documentation
- Re-engagement
- Continued in-clinic treatment

Zero Suicide
Clinical Activities Flowsheet

Improve
For the State:
- Report SPARS data
- Report sentinel events to State, and IHS (if required)

Internal
- Regular chart review
- Repeated Org. Self Survey and Workforce Survey
- Annual Data Elements Worksheet

* Make necessary adjustments to workflow

Follow-Up
- Caring Contacts
- Documentation
- Re-engagement
- Continued in-clinic treatment