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EVALUATION OF DOCUMENTATION OF SAFETY PLANS

A Joint Force Evaluation of the Behavioral Health Team's Documentation of Safety Plans in the
Outpatient Management of Patients Identified as High Risk for Suicide

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Abstract

Phase 2 Site: USAFA, Fort Bliss, and NMRTC Portsmouth.

Project Title: A Joint Service Evaluation of the Behavioral Health Team's Documentation of Safety Plans in the Outpatient Management of Patients Identified at High Risk for Suicide

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Background or Problem Issue: Military suicide has increased each year since 2001. Evidence suggests safety plans are helpful in reducing suicidal behavior. Likewise, provider adherence to Clinical Practice Guidelines (CPG) promotes better patient outcomes.

Clinical Question: Among behavioral health team members completing safety plan documentation at USAFA, Fort Bliss, and NMRTC Portsmouth, how does an educational intervention on the safety plan components of the 2019 VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide impact adherence to the CPG, four weeks after the intervention?

Project Design: A program evaluation and educational intervention that applied the Knowledge to Action Framework to assess the documentation of safety plan interventions as recommended by the 2019 VA/DoD CPG.

Analysis of the Results: A Safety Planning Chart Audit Checklist (SPCAC) assessed adherence and completeness of the six elements of a safety plan. The preliminary analysis of 15 charts at each of the three locations showed: 59% of the charts at USAFA, 17% of the charts at NMRTC Portsmouth, and 20% and 53% of charts at the two sites at Fort Bliss showed adherence. There was a positive trend towards CPG adherence following the educational intervention. The analysis following the intervention shows 71% of the charts at USAFA, 33% of the charts at NMRTC Portsmouth, and 83% and 61% of charts at the two sites at Fort Bliss met adherence to the CPG.

Organizational Impact/Implications for Practice: Standardized safety plan documentation improved adherence and completeness in accordance with the 2019 VA/DoD CPG. Recommend implementing organizational policies to further improve safety plan documentation.

Introduction

Suicide is a complex, multifactorial phenomenon encompassing a wide array of biological, psychological, and social factors influencing an individual's thoughts, emotions, motivations, and behavior. It is a public health crisis that has reached an astounding average rate of 129 suicides occurring each day (American Foundation for Suicide Prevention, 2019). Suicide is the tenth leading cause of death in the United States and the second leading cause of death among active duty service members (USU-CDP, 2019). In addition to the annually increasing numbers, the economic impact of suicide exceeds billions of dollars in medical and workforce loss-related costs each year (CDC, 2017).

Due to the ever-expanding body of research focused on identifying suicide risk, the Department of Veterans Affairs (VA) and Department of Defense Evidence-Based Practice Work Group (EBPWG) updated the clinical practice guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide in 2019. Included within the non-pharmacological risk management and treatment recommendations was the suggestion to complete a safety plan for individuals with past and active suicidal ideations (SI) or previous history of suicide attempt (SA). Although research exclusively examining safety planning efficacy is small, it is gaining momentum. A randomized clinical trial conducted in 2017 found that completing a safety plan reduced suicide attempts among active-duty military members with recent SI (Bryan et al., 2017). Furthermore, research conducted by Green et al. (2018), which this manuscript will explore in-depth, presents solid evidence of how a completed and individualized safety plan can reduce suicidal behavior. Considering this evidence, our project goal was to determine if providing an educational intervention to behavioral health providers on safety plans improved their adherence to CPG documentation within the outpatient setting.

Identifying individuals at risk is critical to reducing the number of deaths by suicide and suicide attempts among active duty service members (SMs). While several risk factors are identified in assessing and managing patients at high risk for suicide, accurate prediction of suicidal behavior and future intent remains challenging in both the general population and clinical setting (VA/DoD, 2019). However, significant efforts were made to improve suicide risk evaluation and assessment, including utilizing a personalized safety plan developed between the provider and patient, emphasizing a stepwise approach to symptom management. A growing body of evidence suggests accurate identification and assessment of warning signs, risk factors, and protective factors is fundamental in developing individualized safety plans to help those in times of crisis and reduce incidents of suicide (Pruitt et al., 2018; VA/DoD, 2019).

Significance of the Problem

In 2018 alone, 541 SMs died by suicide (DoD, 2019). Current data shows a substantial increase in suicides among all service members over the last five years compared to the general population (DoD, 2019). The DoD Annual Suicide Report (2019) found that SMs who died by suicide were primarily enlisted males, using firearms, below 30 years of age. This demographic closely resembles the CDC (2018) findings of suicide being the second leading cause of death for individuals between 10-34 years of age. Additionally, 1,397 non-fatal suicide attempts were made in 2017, further highlighting the immediate demand to address this growing epidemic (Pruitt et al., 2019).

Among SMs who died by suicide, 58% in 2016 and 51.5% in 2017 received care within the Military Health System (MHS) in the 90 days before their death (Pruitt et al., 2019; VA/DoD, 2019). Nearly half of individuals who died by suicide (48.5%), and over half of individuals who

attempted suicide (58.6%), had one or more documented mental health diagnosis. The most common diagnoses being adjustment disorder, substance-use disorder, mood disorder, and anxiety disorder being the most common (Pruitt et al., 2019). This data represents a substantial portion of the at-risk patient population are receiving behavioral health services and provides an enormous opportunity to improve upon suicide risk identification, assessment, and prevention.

Due to expanding research evidence and knowledge concerning suicide risk and prevention strategies, the Department of Veterans Affairs (VA) and Department of Defense (DoD) updated the Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide in 2019 (VA/DoD, 2019). Included in the guideline is the recommendation to complete a crisis response plan or safety plan for individuals with suicidal ideation or any history of suicide attempts as part of their individualized treatment plan (ITP) (VA/DoD, 2019).

A patient safety plan is an evidence-based, personalized strategy developed between patient and provider. It consists of six hierarchical steps that are utilized before or during a crisis to avoid suicidal thinking and behaviors (Green et al., 2018). The six steps include the explicit personal warning signs, effective coping strategies, social support contacts that serve as distractions, family and friends that may offer help, professionals, and agencies available for immediate intervention, and previous steps taken to avoid the use of lethal means (Green et al., 2018; VA/DoD, 2019). This Tri-Service project aimed to evaluate the impact of an educational intervention on behavioral health teams' adherence to documentation of the six elements of the safety plan as described in the 2019 VA/DoD CPG and completeness as recommended by current literature.

Relevance to Military Nursing

Suicide is the 10th leading cause of death and remains a public health crisis. According to the CDC (2015), suicides contribute to an estimated 51 billion dollars in medical and work-related costs annually. Throughout the first decade of the 21st century, rates of suicide in the military have increased dramatically. Specifically, the prevalence of suicide among active-duty SMs and veterans exceeds 6,000 deaths annually (Department of Veteran Affairs, 2018). The rising suicide rates in the VA and DoD populations led to significant increases in efforts to identify individuals at risk for suicide and to implement programs and policies to mitigate that risk. There is a rising demand for military healthcare providers to address this growing epidemic while maintaining personal strength and resilience following the catastrophic experience of losing a patient to suicide.

Advanced Practice Registered Nurses (APRNs) are highly educated, licensed, and certified healthcare professionals who are qualified to provide primary care, emergency care, and behavioral health services to patients. Therefore, regardless of their specialty, they will most likely be involved in the screening, assessment, and management of a patient identified as a suicide risk. Considering the prevalence of suicide in the military and the number of active duty and veteran populations needing behavioral health services projected to increase as many SMs transition to civilian life, it is especially vital for APRNs working in the DoD to understand the updated CPG and know how to effectively and efficiently incorporate it into practice. APRN utilization remains instrumental in helping the VA and DoD meet demand and increase the number of people, programs, and resources dedicated to those seeking mental health care (Department of Veterans Affairs, 2018).

System or Clinical Question

Among Behavioral Health providers (psychiatric nurse practitioners, psychiatrists, social workers, and psychologists) completing safety plan documentation at USAFA, Fort Bliss, and NMRTC Portsmouth, how does an educational intervention identifying the safety plan components of the 2019 VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide impact the adherence to the CPG and completeness of safety plans described by current literature, four to six weeks after the intervention?

Literature Review of Solution

The PICO question used to guide this literature search is: In behavioral health teams working in behavioral health clinics, how does an educational intervention outlining the VA/DoD Clinical Practice Guideline for the assessment and management of patients at risk of suicide, compared to current practices, impact safety plan documentation?

The group searched PubMed, CINAHL, and PsycINFO databases. Inclusion criteria consisted of adult patients, full text articles, and articles published between 2010 and 2019. Search terms of databases included *safety plan*, *safety planning intervention*, and *suicide*. Search terms came up with 142 articles. Duplicate articles were screened and removed, reducing the number of articles to 117. These records were then screened by title and abstract; 95 articles were removed that did not target the clinical question. Exclusion criteria included *children*, *adolescents*, *home health*, *occupational health*, and *lack of safety plan*. Twenty-two full-text articles were assessed for eligibility, and 17 articles were excluded because they used a different intervention than safety planning or did not include an intervention. An article, from the PowerSearch database, about the suicide rate among patients discharged from psychiatric

facilities was included because it had information germane to the topic at hand. A total of five records were included in the final literature synthesis (Appendix D).

The Johns Hopkins Nursing Quality of Evidence Appraisal method was used to appraise the articles (Dearholt & Dang, 2012). The articles chosen consisted of Level I to Level III evidence with variable qualities (Appendix E). The articles included one meta-analysis, one randomized control trial, a cohort study, one qualitative interview study, and one longitudinal study. The limitations for most of the articles were a small sample size and lack of long-term follow-up data. The articles' strengths include that the studies were easy to replicate and were applicable to the military population. The literature synthesis showed that recently discharged patients who are admitted due to suicidal ideations or attempts are at an increased risk of suicide post-discharge from the hospital (Chung et al., 2017). The evidence supports the use of safety planning intervention as a tool to link patients with resources that can minimize their risk for future suicide attempts (Stanley et al., 2016; Bryan et al., 2017; Stanley et al., 2018; Green et al., 2018).

Focus Areas

The primary focus of this project was to improve adherence to the CPG. The project's secondary focus was to assess and impact the completeness of the safety plan documentation from the baseline identification of one item in each of the six elements of the safety plan, as recommended by the 2019 VA/DoD CPG, to identifying up to three items in each of the six elements of the safety plan, as supported by current literature. Our recommendation to the leadership is to prioritize education and training on safety plans by including teaching about safety plans in annual training.

Organizing Framework

We used the Knowledge to Action (K2A) framework because it provided an outline of necessary processes to move from the discovery of information into action that is translatable to evidence-based programs and policies (CDC, 2014). The K2A offered guidance on evaluation and dissemination of a CPG recognized by the World Health Organization (WHO) as a method to implement science (Refer to Project Design for a detailed outline of K2A framework as it pertains to the group's project phases).

The group implemented the knowledge already available in the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide in 2019 into practice in their respective military treatment facilities (MTFs). The Knowledge to Action (K2A) framework contains two distinct elements. The first element is Knowledge Creation which consists of three stages of development. It begins with a knowledge inquiry to determine the amount of evidence available. It is by the synthesis, which consists of synthesizing research data into understandable information for widespread application. The last stage is product tools, which consists of taking the information learned to create the tools or products necessary to present the information (Graham, 2006). The knowledge creation part of the project has already been manufactured in the form of the 2019 VA/DoD CPG on the assessment and management of patients at risk for suicide.

The second element of the K2A framework is the Outer Action Cycle (Application) ring, which is the primary focus of this project. This outer ring examines the different steps needed to implement the knowledge created. These eight steps correlate to the procedural steps outlined in this project proposal. The Action Cycle's first step identifies a problem that needs addressing and selects the knowledge relevant to this problem. The group identified that the increase in

suicide rates in the military is a grievous problem. The VA/DoD created the 2019 CPG, and it outlined how BH providers and patients should be completing the safety plan collaboratively (Phase 1). In the second phase, the group assessed the adherence to the CPG using the Safety Planning Chart Audit Checklist (SPCAC). Concurrently, the group also assessed the charts based on Green *et al.* article definition of quality and completeness, which the group shared during the intervention (Phase 2). In Phase 3, the group implemented the educational intervention, which included education about the findings from the retrospective chart reviews/SPCAC, data synthesized from the literature review, and completing the safety template. Phase 3 also included sharing the 2020 VA/DoD Safety Plan template. As part of the last phase, the group evaluated post-intervention results using the same pre-intervention chart audit. Then the group documented the final results and evaluated outcomes for dissemination to the three MTFs (Phase 4).

Project Design

General Approach

This project constitutes a program evaluation of pre and post educational intervention of the behavioral health team's adherence to completing all six elements of the safety plan as described in the 2019 VA/DoD CPG. Secondly, it will evaluate the completeness of safety plans in relation to current literature recommendations.

Setting and Population

A unique and significant component of this project is the Tri-service involvement across three different military installations and three different service affiliation. At each of the three sites, there was a minimum of one project team member of the respective service affiliation actively engaged for the project's duration. The sites included: William Beaumont Army Medical

Center, Navy Medicine Readiness and Training Command (NMRTC) Portsmouth, and the United States Air Force Academy (USAFA).

The Army component of this project took place at William Beaumont Army Medical Center (WBAMC) located on Fort Bliss in El Paso, TX. WBAMC provides comprehensive services to over 38,500 active duty service members, their families, and retired beneficiaries (Fort Bliss Army Base in El Paso, n.d.). Overall, the U.S. Army is estimated to have 471,990 active duty personnel with 462 reported suicide attempts in CY 2018 (Tucker, Smolenski & Kennedy, 2019). Office of the Surgeon General, Medical Command (OTSG/MEDCOM) Policy Memo 16-096 is the local policy that governs the Behavioral Health At-Risk Management Policy (ARCT) at WBAMC. This policy states that Behavioral Health (BH) providers will perform and determine a risk assessment on initial and subsequent behavioral health encounters. If the patient is determined to be High BH Risk the patient will be mandatorily enrolled in the ARCT list. These patients will include, but are not limited to: Patients discharged from a BH acute or residential inpatient unit in the last 30 days; Patients known to have had a suicide attempt in the past 60 days; and Soldiers medically evacuated from Theater for a BH reason in the last 30 days. The policy also dictates that a specific safety plan utilizing the following elements should be developed with and given to the patient: (1) distraction techniques; (2) social support with contact numbers; (3) removal of means to inflict self-directed violence and (4) professional agencies to contact in emergency situations (4/6 of the recommended elements recommended in the CPG). Per policy, the form does not need to be loaded into AHLTA, but a documented summary of safety planning with the patient should occur. It also states that on follow-up clinical encounters, BH providers will utilize and document, at a minimum, the presence or

absence of current suicidal or homicidal ideation and any context-relevant risk assessment items reviewed during the clinical encounter (Department of the Army, 2016).

The Navy component took place at NMRTC Portsmouth in Portsmouth, VA. This large facility provides care to 180,000 active duty members, their families, and retirees (Naval Medical Center Portsmouth, n.d.). The Navy has an estimated 325,395 sailors within its ranks, of which 218 attempted suicide in CY 2018 (Duffin, 2019; Tucker et al., 2019). Officially, there is no established policy at NMRTC Portsmouth that specifically requires behavior health team members to complete a safety plan with patients in the outpatient setting. Likewise, there is no specific criteria for placing someone on the High Interest List (HIL). Unofficially, the criteria for placing someone onto the HIL at NMRTC Portsmouth is based upon several factors which include: a behavior health provider's judgment that increased monitoring is indicated, chronic suicidality, inpatient hospitalizations, as well as having a psychiatric diagnosis that places the patient at a higher risk for harm to self, others, or the mission. Also, at a minimum, patients placed on the HIL are in a limited duty (LIMDU) status and in most cases, they are also awaiting a physical evaluation board (PEB). Furthermore, patients placed on the HIL are monitored by the Psychiatry Continuity at Treatment (PCaT) clinic. The PCaT staff closely monitors the improvement and/or exacerbation of symptoms by conducting a weekly safety check with all HIL patients. These safety checks include the use of a Columbia-Suicide Severity Rating Scale (C-SSRS) to assess risk for suicide. In addition to the weekly safety check, PCaT staff also coordinate care for the high interest patient throughout their time in LIMDU or PEB status.

The Air Force component took place at the U.S. Air Force Academy, 10th Medical Group in Colorado Springs, Colorado. This facility provides comprehensive healthcare services to 30,000 beneficiaries, including 4,000 cadets (Air Force Medical Service: 10th Medical Group

U.S. Air Force Academy, n.d.). In CY 2018, there were 352 reported suicide attempts out of 321,618 total estimated airmen in the force (Tucker et al., 2019; Duffin, 2019). The policy utilized to manage patients placed upon the HIL is Air Force Instruction (AFI) 44-172. This policy states “The HIL serves as a communication strategy for coordinating care, closely monitoring the improvement and/or exacerbation of symptoms, and ensuring timely delivery of treatment” (AFI 44-172, 2015, p.27). The criteria for placing someone onto the HIL is based upon several factors which include: the provider's judgment that increased monitoring is indicated, risk for harm to self, others, or the mission, admission or discharge from inpatient hospitalization, and patients being seen in Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program and Family Advocacy Program (FAP). The policy recommends completing the HIL Hospitalization Checklist (located in the Knowledge Exchange (KX) in Air Force Portal) to assist in the tracking of HIL patients. This checklist contains an area to complete a safety plan if indicated. The AFI 44-172 requires that a safety plan be completed on patients post discharge from inpatient hospitalization with the support and collaboration of the patient's commander. However, it does not specifically address completing a safety plan for patients on the HIL (2015).

The population focus for the chart review was active duty servicemembers identified as high risk for suicide. A challenge for this project was difficulty with identifying patients at high risk for suicide related to lack of clear ICD10 diagnosis for suicide. While the CPG identifies that Mood Disorders, Anxiety Disorders, and Substance Use Disorders often place the patient at a higher risk for suicide, their clinical risk assessment does not always merit a safety plan (VA/DoD, 2019, p. 31). To enhance probability of identifying active duty servicemembers identified as high risk for suicide a convenience sample was used based on the population most likely to have a safety plan. This population, as discussed previously, is known by the Army as

the At-Risk Case Tracking (ARCT), and is known by the Navy and Air Force as the High-Interest lists (HIL).

The population focus for the educational intervention of this project was behavioral healthcare providers at each of these installations involved in safety plan documentation. These included active-duty, contractors, and GS civilian physicians, psychologists, advanced practice registered nurses, social workers, and physician assistants who work in outpatient behavioral health clinics. Any healthcare providers that were not credentialed to create and document safety plans in behavioral health patients or worked outside the behavioral health setting were excluded.

Procedural Steps

The overall goal for this project was to improve documentation of all six elements of the safety plan. Appendix B includes a visual representation of the four phases of this project, and Appendix C displays the timeline of the procedural steps.

Phase One: Identify a Problem

This project's first phase is problem identification which was clearly defined in the recent revision of the 2019 VA/DoD CPG for patients at risk for suicide and the 2019 Department of Defence Suicide Event Report (DODSER) data. It is clear that the military continues to have a problem with suicide, and further intervention is required. Interestingly, the literature review the group conducted and the 2019 VA/DoD CPG supports the use of safety plans to decrease the risk of suicide. More specifically, Gamarra et al. (2015) report an increase in attendance for outpatient mental health visits with a complete safety plan. Even further, there was a significant association with the total quality of the safety plan and a decrease in subsequent hospitalizations. Subsequently, the focus of this project was to evaluate adherence to the current 2019 VA/DoD CPG as well as completion of the safety plan as described by Green et al. (2018).

Phase Two: Identify, Review, and Select Knowledge

The second phase of the project aimed to establish inter-rater reliability and assess baseline levels of adherence and completion of safety plan documentation at each clinical site. These levels were determined through pre-intervention, retrospective chart reviews utilizing the customized audit tool (SPCAC) at each clinical site.

As described previously, the selection process included charts in the ARCT or HIL during the identified two-week data collection period. A large majority of patients meet high-risk designation as determined by the presentation of essential features listed within the 2019 VA/DoD CPG and require a well-articulated safety plan (VA/DoD, 2019). Our procedure, before scoring the full project, was to determine interrater reliability of chart scoring by using a pilot sample of five charts. Each of the five evaluators across three clinical sites utilized the SPCAC to score the same five charts for adherence and completeness. The five charts used for the inter-rater reliability review were chosen at random from the ARCT. After charts were selected, the Medical Record Number (MRN) was used to locate the most recent behavioral health encounter within the military electronic health record known as the Armed Forces Health Longitudinal Technology Application (AHLTA). If there were no safety plans found within the last outpatient behavioral health encounter, the evaluators continued to review charts in reverse chronological order not exceeding three behavioral health encounters. Each evaluator scored those charts with the SPCAC, a grading tool for safety plan completeness and quality based on Green et al. (2018) and the 2019 VA/DoD CPG, which is included in Appendix F. Of note, Green et al. (2018) considers three items listed in each of the six components of the safety plan as complete, whereas, the CPG accepts one item per component. For this project's purpose, the group customized the audit tool from Green et al. (2018) to collect scores for both criteria, adherence

meaning one item per component as directed in the CPG and completeness meaning 3 items per component as recommended by the Green et al. article. To ensure that a standardized chart review method occurred at each location, evaluators compared scoring consistency between the group members. Any variations between scoring were corrected before the full project chart review conduction. For the full chart review, fifteen charts were selected per variable recommended by Gearing et al. (2006). For this review, there is one variable, completeness. This resulted in 45 individual chart reviews over three separate clinical sites (one of each ARMY, AIR FORCE, and NAVY). To meet this threshold two weeks of ARCT and HIL were required. A more thorough explanation of scoring criteria can be found in the data analysis plan section of this manuscript.

Phase Three: Adapt Knowledge to Local Context, Assess Barriers to Knowledge

Use, & Select, Tailor, Implement Interventions

The third phase of the project included identifying and addressing knowledge gaps related to the safety plan intervention and its documentation based on adherence and completeness scores from step two. The group reviewed and analyzed the data gathered from the initial chart reviews at each site. After the local analysis was performed, data analysis and synthesis from all three sites were compiled for evaluation and determination of trends in adherence to the CPG and the identification of common barriers across the services. Some examples of potential barriers are: inconsistent training or education for documentation; lack of engagement to implement the process; and other institutional processes that inhibit proper implementation. Different aspects may prevent the institutions from achieving the standard. An assessment of those aspects can facilitate a proper solution and ease implementation.

The next phase of the project was behavioral health provider educational interventions focusing on safety planning and familiarizing providers with standardized safety plan documentation tools (worksheets) that can be implemented into clinical practice (See appendix G). A study by Feeley, DeRubeis, & Gelfand (1999) reports an association with greater protocol adherence with subsequent symptom improvement. Therefore, standardization of documentation protocols throughout the facilities is predicted to improve patient outcomes. To facilitate this process, each site was provided with three components to the educational intervention. These included: feedback on the initial chart review findings, safety plan best practices, and new processes for utilizing standardized safety plan documentation. Due to COVID and social distancing restrictions, this training was provided virtually to all behavioral health providers. Data suggests that higher-quality safety plans, which consist of a more significant number of items listed and personally relevant to the patient, predict a decreased likelihood of future suicide behavior (Green et al., 2018). This suggests increasing the current documentation requirement from one item in each component of the safety plan as required by the 2019 VA/DoD CPG to three items in each component will increase the completeness of the safety plan, which ultimately is tied to decreased suicidal behavior. Therefore, the standardized safety plan documentation requires three items in each of the six components of the safety plan. This phase concluded with a post-intervention retrospective chart review conducted four weeks after the training and educational intervention occurred. The charts reviewed in the post intervention chart review were selected from the most recent ARCT or HIL excluding charts of patients that had been used on the pre intervention chart review.

Phase Four: Evaluation

Phase four included evaluation and synthesis of post educational intervention data from each site and across the military services. Lastly, the group provided information and recommendations to local department chiefs and key stakeholders based on each site's results and across the organizations. These recommendations can be found in the Organizational Impact/Implications for Practice and Policy Future and Directions for Research and Practice sections of this paper.

Data Analysis Plan

The variables examined were the adherence to the CPG and completeness of safety plan documentation before the educational intervention about safety plan components of the VA/DoD Clinical Practice Guideline for assessing and managing patients at risk of suicide compared to completeness after the educational intervention. The group reviewed the relevant charts of patients assessed as high risk, and determined the adherence to the safety plan guidelines and the completeness of the individual components of the safety plan. The SPCAC was used to record the outcome of the charts reviewed. Adherence is determined by having a minimum of one item in each of the six components of a safety plan for a maximum score of 6, while completeness is calculated by having a minimum of three items in each of the six components of a safety plan for a maximum score of 18.

The findings of the chart reviews showed that some patients never received a safety plan, some plans were never updated, and that low-quality safety plans result from lack of training for staff members. Low quality safety plans include partially completed safety plans and safety plans that are not relevant to the patient. Improving the quality and completeness of a safety plan decreases the risk of suicide (Green et al., 2018). According to Green et al., higher safety plan completion scores (greater than 90%) predicted a decreased likelihood of future suicide behavior

reports (2018). After all pertinent records were assessed for completeness and adherence, the analysis then examined each facility's trends.

Potential Barriers

Suicide is not a disease but a risk factor associated with different mental health conditions, and currently, there is no specific diagnosis for suicide behavior listed within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The lack of a suicide diagnosis may impede locating appropriate charts. To address this, we will use the at-risk case tracking forms and the high-interest list, which classify patients that are assessed as high risk. Another potential barrier is incorrect coding of patients who may fail to obtain the necessary patient medical records. The possibility that there may not be a sufficient number of charts to evaluate based upon the criteria is also a potential barrier. We do anticipate this issue but will adjust if necessary.

Sustainment and Dissemination Plan

After completing the project's intervention, which included training and review of results from the initial audit, the group compiled the results from the chart reviews and the evidence from the literature search for dissemination within the respective MTFs and with Uniformed Services University (USU) colleagues for Research Week 2021. The group published the results via a synthesis paper, a PowerPoint presentation, and a poster board after approval from the Public Affairs Officer (PAO) at individual sites.

This DNP project's utilization and sustainment echoes the values of the Quadruple Aim and the progress towards value-based care and a high reliability organization. Based on the literature review, retention of material and knowledge of CPGs tend to decline after a year (Ament et al., 2015). The group's results across all three MTFs demonstrated an immediate

increase in CPG adherence and safety plan completion post-implementation. Based on this finding and the expected and eventual turnover of staff, it is imperative to sustain an annual training plan for primary care and behavioral health providers, to include regular chart reviews. The group shared the training plan, the PowerPoint presentation (about safety plan completion), and the SPCAC with the local facility for future use, which included the recommendation to conduct an initial and an annual safety plan completion training for staff and creating continuing education (CE) computer-based training with platforms such as RELIAS or Joint Knowledge (JKO). Green et al., (2018) highly suggest provider training as future recommendation, as well, in that it can only help strengthen the fidelity around an intervention already utilized across the MHS and VA/DoD. To help further, we recommended appointing CPG champions who can ensure continuity of training and chart reviews. Another recommendation is incorporating the SPCAC into the existing chart review forms. The champions will make sure that providers maintain competency in completing the safety plans.

Furthermore, studies showed that 50% of individuals that attempted suicide saw a healthcare provider within the last three months before their attempt, most likely a primary care provider (DODSER, 2019). For this matter, the group recommended that safety plans be made accessible to primary care providers. Safety plans should be reviewed by behavioral health providers and discussed by primary care providers, especially when suicidal behaviors are part of the individual's history.

Additionally, for the convenience of the sampling, the group chose the HIL to obtain patient charts for review. Although most patients on the HIL generally meet requirements to have a safety plan, some patients do not warrant one. For example, patients in a partial hospital program (PHP) or an intensive outpatient program (IOP) are added to the HIL for tracking

purposes and not solely due to safety concerns. However, policy should reflect the importance of completing a safety plan with a patient if they are endorsing suicidal ideations and/or at an elevated risk for suicide. With the eventual merging of the Department of Health Agency (DHA) and the Military Health Service (MHS), standardization across the facilities, to include training and documentation, is warranted. It would smooth out the process and allow for more collaboration and cooperation between the departments and MTFs.

HIPAA Concerns/Ethical Considerations

Safeguarding protected health information (PHI) was a priority of this evidence-based practice (EBP) project. The team collected data points from the chart reviews of ARCT or HIL, to evaluate the adherence to the six elements of the safety plan outlined by the 2019 VA/DoD Clinical Practice for the Assessment and Management of Patients at Risk for Suicide. This project focused on evaluating the completeness of patient safety plans under the 2019 CPG, not individual patient outcomes. Personally identifiable information (PII) and protected health information (PHI) was not necessary for this portion of the project, and the team took additional steps to not transcribe PII and PHI into the chart review checklists. The team identified legal and ethical implications for this EBP project. This project was submitted as a program evaluation, as it did not meet criteria for research. The team sought an Institutional Review Board (IRB) exemption. All data was stored on a CAC-enabled computer in a locked, badge-accessed room, available only to project staff. All physical data was stored in a locked room and subsequently disposed of per HIPAA regulation upon this EBP project's conclusion.

Project Results

The tri-service team conducted a second retrospective chart review four to six weeks after the educational intervention to determine if there was a change in adherence to the CPG and completeness of safety plans. The Fort Bliss team conducted the second chart review for the two Fort Bliss sites six weeks after the educational intervention and the results showed an improvement in the completeness of the safety plan and adherence to CPG at the two sites (West Bliss BH and 2/1 EBH) where charts were reviewed. Per the OTSG/MEDCOM Policy Memo 16-096, all charts reviewed should include safety plans. We reviewed a total of 15 charts at the two Ft Bliss sites, pre and post educational intervention, and they all have safety plans.

The completeness of the safety plan at West Bliss BH went from 18% to 67% and adherence to CPG from 20% to 83%. The completeness of the individual components at West Bliss is as follows: *Warning Signs* from 0% to 67%, *Internal Coping Strategies* from 0% to 67%, *Social Contacts and Locations that Serve as Distractions* from 0% to 52%, *Family Members or Friends that May Offer Help* from 7% to 70%, *Professionals or Agencies* from 100% to 100%, and *Reducing the Potential for Use of Lethal Means* from 0% to 44%.

The completeness of safety plans at 2/1 EBH went from 40% to 48% and adherence to the CPG went from 53% to 61%. There was improvement in four of the six components, no change in one component, and a reduction in of the components. The completeness of the individual components at 2/1 EBH is as follows: *Warning Signs* from 28% to 0%, *Internal Coping Strategies* from 11% to 39%, *Social Contacts and Locations that Serve as Distractions* from 17% to 33%, *Family Members or Friends that May Offer Help* from 50% to 50%,

Professionals or Agencies from 89% to 100%, and *Reducing the Potential for Use of Lethal Means* from 44% to 67%.

The United States Air Force Academy (USAFA) team conducted the second chart review five weeks after the educational intervention and the results demonstrated an improvement in the completeness of safety plan and adherence to CPG. The results show that the completeness of safety plans at USAFA went from 51% to 67% and adherence to CPG went from 59% to 71%. The completeness of the individual components at USAFA is as follows: *Warning Signs* from 56% to 64%, *Internal Coping Strategies* from 56% to 69%, *Social Contacts and Locations that Serve as distractions* from 56% to 69%, *Family Members or Friends that May Offer help* from 44% to 64%, *Professionals or Agencies* from 56% to 69%, and *Reducing the Potential for Use of Lethal Means* from 40% to 64%.

The Portsmouth team conducted the second chart review four weeks after the educational intervention and the results also revealed some improvement in the completeness of safety plan and adherence to CPG. The results show that the completeness of safety plans at Portsmouth went from 13% to 23% and adherence to CPG went from 19% to 33% despite an improvement in only two of the six components. The completeness of the individual components at Portsmouth is as follows: *Warning Signs* from 0% to 0%, *Internal Coping Strategies* from 0% to 0%, *Social Contacts and Locations that Serve as Distractions* from 0% to 0%, *Family Members or Friends that May Offer Help* from 0% to 0%, *Professionals or Agencies* from 53% to 100%, and *Reducing the Potential for Use of Lethal Means* from 22% to 36%. Of note, every HIL patient chart at NMRTC contained elements of a safety plan regardless of whether the patient was considered at risk for suicide per the CPG. Furthermore, despite not having a safety plan containing the six elements that this project specifically looked for, in the recommendations

section of each chart, the provider annotated “reviewed safety plan with patient, patient is aware of who they can call and/or where he/she could go in during a crisis.” Also, the NMRTC behavioral health providers specifically documented the patient’s access to lethal means, as well as if they reviewed/discussed with the patient places to go or professional agencies to seek out in times of crisis. This is evidenced by the lack of change in documentation in four of the six elements of a safety plan following the educational intervention.

The adherence and completeness scores at Ft Bliss sites, USAFA and Portsmouth were all less than 90% which is the percentage correlating to a decrease in future suicidal behavior (Green et al., 2018). The trend, however, shows positive increases in both adherence and completeness scores at all locations.

Analysis of Results

Following the educational intervention and recommendation of a standardized safety plan template, all three clinical sites showed improvement. There were several contributing factors that potentially influenced the pre and post intervention data. The provider questionnaire, intended to measure baseline understanding of the six elements addressed in the safety plan intervention, was not conducted due to time constraints and the lengthy IRB approval process. Additionally, our sample data was drawn from each clinic-specific, patient high-interest list that is assembled based upon multi-factorial assessment and site-specific criteria, and not exclusively for patients at risk for suicide. For example, a service member may be placed upon the high interest list due to an alcohol related incident such as underage drinking. In this scenario, the patient may have no imminent risk factors for suicide, however clinic policy dictates the patient be placed on the high interest list for

higher visibility and regularly scheduled alcohol/drug related education and counseling. Finally, there were no specific clinic policies delineating how and when to document the safety plan intervention. Since the safety plan is an additional document that must be added to the patient record, it is possible safety plans were completed but had not been scanned into the patient record at the time of our chart audit.

Considering these factors and evidence from the literature, recommendations to improve safety plan completion across all three clinical sites include system, process, and clinical practice initiatives. A standardized template such as the VA/DoD Safety Plan Worksheet (2020) that addresses all six components of the safety plan intervention is evidence-based and supported by the literature. Each item listed on the safety plan can decrease future suicide related behavior and suicide events by 10% (Green et al., 2018). Another system/process recommendation is to incorporate the safety plan template into the provider note or embed a link to the worksheet within the electronic health record (EHR). If strategically placed within the section where the provider documents static, dynamic, and protective factors, this would facilitate a smooth transition during the patient encounter, further enhance suicide risk assessment, and increase safety plan completion. Additionally, allowing primary care providers access to review the safety plan during their encounters could further improve completion efforts while solidifying a multi-discipline therapeutic alliance. As Zonana et al. (2017) found, outpatient safety planning can improve healthcare resource utilization and enhance patient engagement. Finally, as Green et al. (2018) noted, lack of formalized training is the most likely factor preventing safety plan completion. Prioritizing education and training on safety plans by including the

teaching in new member orientation and annual training would further improve and sustain this EBP process change.

Organizational Impact/ Implications for Practice and Policy

The primary focus of this project was program evaluation based on the 2019 VA/DoD CPG recommendations. The secondary focus of this project was to assess and subsequently improve the quality of safety plan documentation from the baseline identification of one item in each of the six elements of the safety plan as recommended by the 2019 VA/DoD CPG, to identifying up to three items in each element as supported by current literature. Positive post intervention data findings in the form of increased safety plan completion scores suggest that the adoption of standardized safety plans across the MHS will improve both CPG adherence and quality of safety plans being used.

The primary barrier to completion of safety documentation in this project was the lack of established policies dictating safety plan documentation at the outpatient setting in the MTF. While the VA/DoD CPG makes the recommendation for using a safety plan in patients at high and moderate risk for suicide, there remains a gap in the Defense Health Agency (DHA) and local policies for what documentation is required in the outpatient setting and at what interval. Therefore, organizational impact and implications for practice and policy are to gain strong leadership support and create organizational requirements for safety plan documentation in the outpatient setting for improved quality of care. Additionally, the impending military medical command reorganization may provide an opportune time for implementation as the individual services will merge under one unified medical command, DHA.

Future Directions for Research and Practice

The team hopes that the positive outcomes of this project will be reflected in the increase in patient satisfaction scores (via Joint Outpatient Experience Surveys [JOES]), decrease in inpatient psychiatric hospitalizations, and improvement in primary and secondary mental health services (via Health Effectiveness Data and Information System [HEDIS]). For documentation, completing the safety plan intervention worksheet in writing and scanning into the patient's EHR will suffice for now. Working with the IT department or the Nurse Informatician (NI) might also be an avenue for streamlining the process and accessing the safety plans. The VA/DoD created a safety plan template that can be filled out and scanned into the patient's EHR (2020). Future recommendations include embedment of the safety plan template and VA/DoD Suicide Safety Plan CPG elements into the Electronic Health Record (i.e. MHS Genesis). For provider training, including a pre-intervention questionnaire, which would assess prior provider training about safety planning, knowledge of CPGs, and local practices, could be helpful in tailoring the training for the individual MTF based on the results of the literature review (Ament et al., 2015).

Because the team utilized the HIL and ARCT, one of the dilemmas the team came across during the audit was that not all patients in the HIL or ARCT needed a safety plan. However, their participation in Partial hospitalizations Program (PHP) and Intensive outpatient program (IOP) necessitated their automatic enrollment into the HIL and ARCT. A possible study for the future is more research about which patients may benefit from having a safety plan (Zonana, Simberlund, & Christos, 2018). A second recommendation for future studies is weighing the benefits of a hard-copy of a safety plan vs. safety plans in mobile formats (Kayman, Goldstein, Dixon, & Goodman, 2015). Mobile phones are always within reach and mobile applications

(apps) are bountiful such as the PTSD Coach app created by the VA/DoD. It includes a template for safety planning that the patient can email to safety contacts and also save on his/her phone for access in times of crisis. According to Melvin et al., (2009) mobile applications are a feasible and effective adjunct to standard mental health interventions among patients at risk for suicide.

Conclusion

As suicide rates continue to rise in the military population, so has the need to implement programs and policies to mitigate that risk. The 2019 VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide assists practitioners in mitigating such risk. Moreover, adherence to the CPG ensures that behavioral health providers are both knowledgeable and sufficiently adept at making clinical decisions that result in improved patient outcomes. The CPG recommendation of using safety plan interventions to mitigate risk is supported by data that shows safety plans decrease future suicidal behavior. Nevertheless, this project found that without strong leadership support or an institutional requirement to document safety plans, accountability for completion is difficult. Fortunately, recommendations were well received by behavioral health leadership at USAFA, Fort Bliss, and NMRTC Portsmouth, all of whom have begun to take the necessary steps towards improving safety plan documentation.

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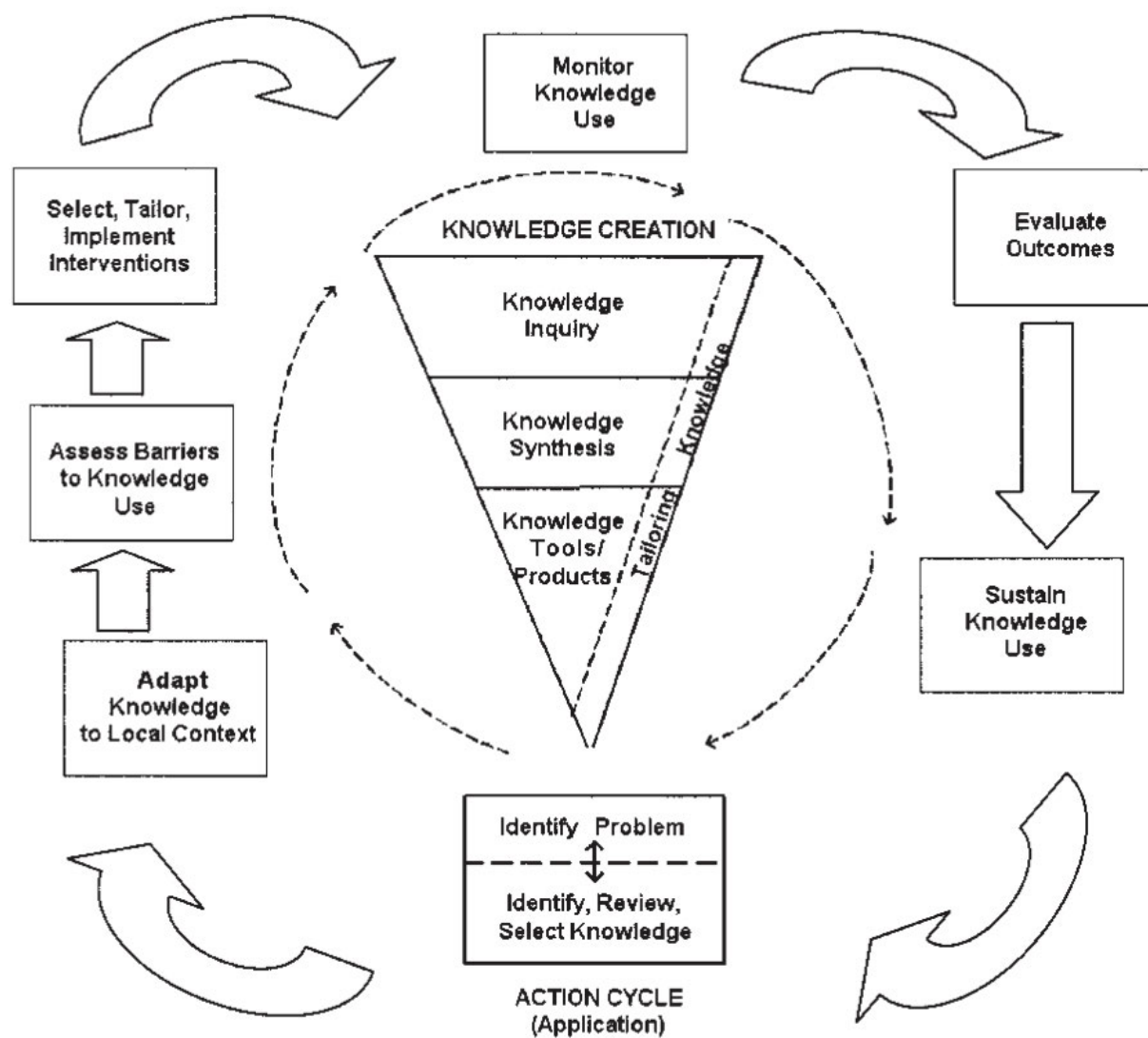
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Appendix A

Knowledge to Action Framework



(Graham, 2006, p. 19)

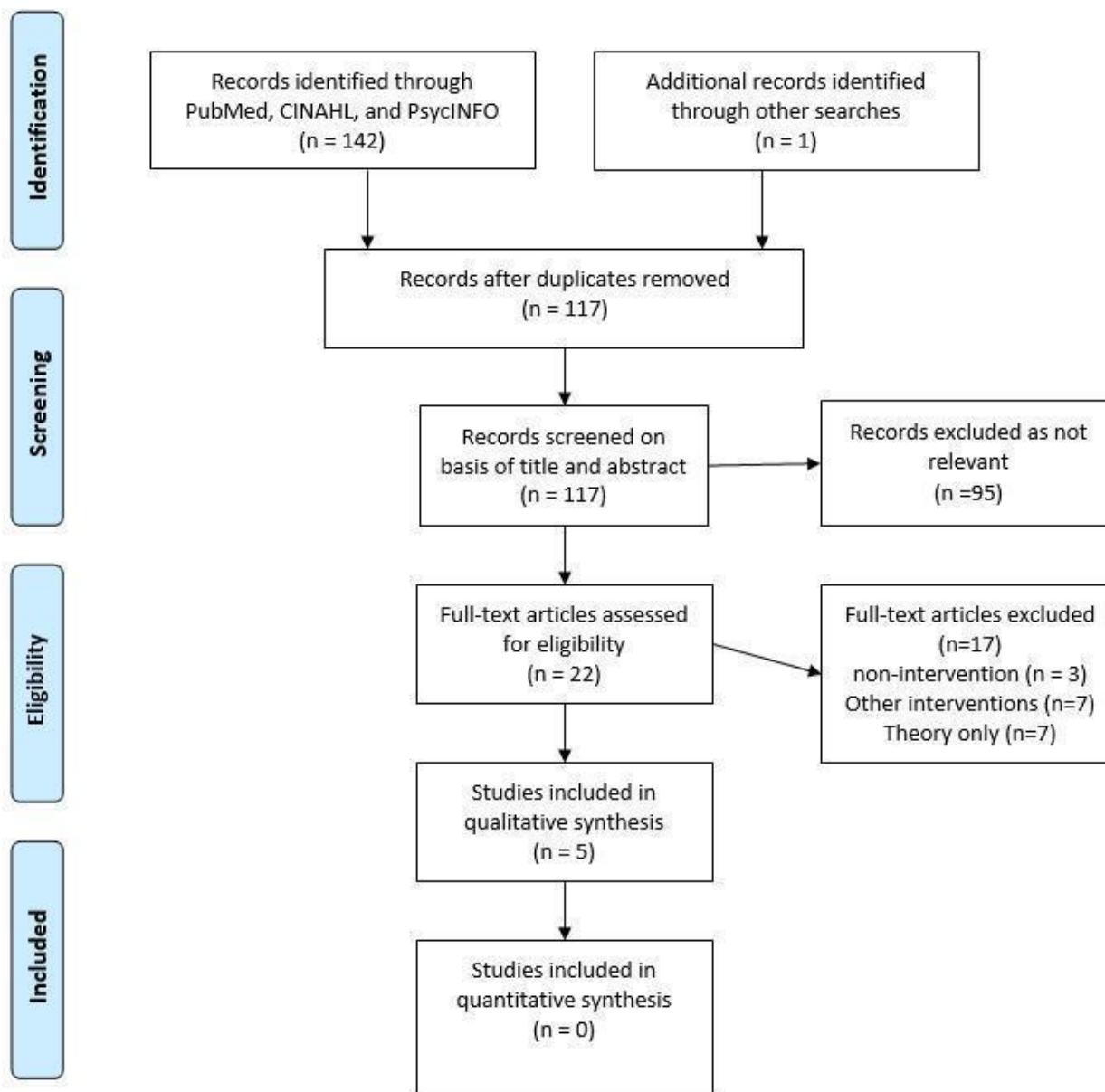
Appendix B

Identify a Problem	Identify, Review, Select Knowledge	Adapt Knowledge to Local Context, Assess Barriers to Knowledge Use, & Select/Tailor/Implement Interventions	Monitor Knowledge Use & Evaluate Outcomes	Sustain Knowledge Use
Phase 1 (Identify a problem)	Phase 2 (Identify review & select the knowledge relevant to the problem)	Phase 3 (Assess barriers to knowledge/Adapt knowledge to local context/Implement Interventions)	Phase 4 (Evaluation)	Impact (Organizational sustainments)
Implementation of 2019 VA/DOD Suicide CPG implies continued problem with suicide prevention intervention	Assess adherence to 2019 VA/DOD Suicide CPG on Safety Planning Intervention (SPI) through Retrospective Chart Reviews Audit Safety Plans (SPs) using Safety Planning Chart Audit Checklist (SPCAC) for adherence to the VA/DoD CPGs (Primary outcome). Concurrently, data will also be collected based on Green article's quality and completeness (For eduction purposes)	Identify knowledge gaps Address knowledge gaps in safety planning intervention and its documentation at each site Implement teaching intervention on Safety Plans based on first round of chart reviews (retrospective) and SPCAC. As well as, implementation of a safety plan intervention worksheet.	Evaluate intervention results and recognize trends Report on post-intervention results (second round of chart reviews) and provide recommendations to key stakeholders in each site and across the organizations	Identify and Address knowledge gaps to safety plan intervention across the services Increase adherence to safety plan intervention across services Standardize documentation across the services Increased adherence to SPI to inversly impact suicide rates across the military

Appendix C

2019												
Activity/ Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
SIP Development & Collaboration with Site Director										x		
USUHS VPR Submission and Approval										x		
Literature Review to Evaluate SPI										x		
Synthesize EBP Data										x		
Literature Review to Evaluate Interventions											x	
Generate EBP Intervention											x	
Generate Intervention Information											x	
Add to Team of Stakeholders and Champions											x	
2020												
Activity/ Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Submit IRB Proposal									x			
Plan for Contingencies to Possible Barriers		x										
Achieve IRB Approval									x	x		
Verify Inter rater reliability											x	
Conduct Provider Questionnaire & Record Review											x	
Collect and summarize site specific data											x	x
Synthesize data across sites												x
2021												
Activity/ Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Conduct site specific training on intervention	x											
Implement intervention	x	x										
Conduct post intervention chart review			x									
Collect and summarize site specific data			x									
Synthesize data across sites			x	x								
Develop Sustainment Plan & recommendations				x								
Disseminate findings to stakeholders				x								
Make recommendations for sustainment				x								
Prepare Publication Ready Document				x	x							

Appendix D



Appendix E

Evidence Table

Chung et al., 2017	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	Systematic review and meta-analysis to quantify the rates of suicide after discharge from psychiatric facilities and examine what moderates those rates.	A synthesis of the existing literature about rates of post-discharge suicide would help quantify the extent of this issue and would complement an earlier meta-analysis of risk factors for post discharge suicide by estimating expected base rates.	The meta-analysis adhered to Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) and Meta-analysis of Observational Studies in Epidemiology (MOOSE) guidelines. A random-effects model was used to calculate a pooled estimate of post discharge suicides per 100 000 person-years.	A total of 142 full-text peer-reviewed publications met our inclusion criteria before being examined for possible overlapping participants. 42 publications were removed for overlapping publications leaving a total of 100 studies were included for analysis	We included studies that reported the number of suicides among patients discharged from psychiatric hospitals or wards and the number of person-years in which the suicides occurred. We also included studies from which these data could be calculated using the reported suicide rate, the mean length of patient follow-up, or the duration of follow-up.	The suicide rates after discharge from psychiatric facilities was the measured outcome
JHNEBP Level of Evidence Level IB	Statistical Analyses		Results	Strengths	Weaknesses	DV
	The studies were weighted according to their inverse variance, τ^2 was calculated using the Paule- Mandel method, and the suicide rates were log transformed and reported in rates per 100 000 person-years. The significance test of the pooled suicide rate was conducted with a null hypothesis of 11.4 events per 100 000 person-years. Between-study heterogeneity was assessed using the Cochran Q and I2 statistics. Possible publication bias was tested by examination of the funnel plot and by an Egger regression.		The immediate post discharge period is a time of marked risk, but rates of suicide remain high for many years after discharge. Patients admitted because of suicidal ideas or behaviors and those in the first months after discharge should be a particular focus of concern. Previously admitted patients should be able to access long-term care and assistance.	Strong identification that immediate post discharge has a high risk of suicide. That risk remains from the first month post discharge and continues on over years.	High sample heterogeneity attributed to the primary research. The data identified a large number of studies. The calculated rate of suicide is estimated at 3 times the any comparable study.	Association between duration of follow-up and the year of the sample were the main priori moderators
Green et al., 2018	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	To examine if personally relevant, high quality SPs reduced suicide related outcomes (psychiatric hospitalizations, self harm, & suicide attempts)	1. What effect does a completed and high quality SP have on predicting future suicide-related behavior? 2. Of the six hierarchical steps of the SP, do certain steps (family/friends, lethal means restriction) have a greater impact on reducing suicidal behavior? Hypothesis: lethal means restriction is most important.	Study authors developed an SP scoring system guided by VA/DoD CPGs that examined completeness and quality. One point was awarded for each completed item. One point removed for each completed item that was not appropriate/relevant when compared to Risk Assessment. (Plan to shoot self and lethal means restriction did not address removing firearms from home) Total score was 0-18 with 18 being the highest possible score.	Convenience sample of 68 OEF/OIF veterans enrolled in Project Valor who had been referred to Suicide Prevention Service at VA.	1,649 participants initially screened resulting in 68 individuals meeting criteria. Participants had been referred for Suicide Prevention Service for SI/SA and data entered into Va's Suicide Prevention Applications Network (SPAN).	Risk Assessment conducted/on file. SP on file. New SP completed following SPAN event, and SP scoring.
JHNEBP Level of Evidence Level IIIB	Statistical Analyses		Results	Strengths	Weaknesses	DV
	1. Zero-order correlations and chi-squares to determine if demographics and history were related to independent or dependent variables. 2. Binary logistic regressions to determine if SP scores (completeness, quality, total score) predicted suicide related outcomes. 3. Binary logistics regression to determine which of the 6 steps were most effective at reducing suicide related outcomes.		Higher SP completion scores and total scores predicted a decreased likelihood of future SBRs. Higher total scores on step 3 (people & places that serve as distractions) predicted a decreased likelihood of future SBRs. No other SP steps predicted suicide-related outcomes. Effect size for SP total scores, quality scores, completeness scores, and higher total scores on step 3 using AOR suggest a larger sample size would have shown statistically significant findings.	Higher quality SPs (items personally relevant) predicted decreased likelihood of future SBRs. Using AOR, each high-quality item listed on SP decreased likelihood of future suicide-related events by 10%. Findings suggest a great opportunity to develop and implement training for SP completion and quality	An additional 44 participants would have been needed for the study to be appropriately powered. Study data only included information in VA databases and did not account for veterans receiving care outside	Suicide related outcomes - SBRs - Suicidal behavior reports (Psychiatric hospitalization, suicide attempt, suicide death within the time of completing SP following SPAN event.

Stanley et al., 2018	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	To determine whether Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge.	Can a brief suicide prevention intervention reduce suicidal behaviors and improve treatment engagement among patients who present to the ED for suicide-related concerns?	Cohort comparison design with 6-month follow-up	N=1640 patients; Intervention group=1186; Comparison group=455	Patients were retrospectively assigned. All eligible patients were provided usual care and SPI+ as standard care in the intervention group (5 VA ED where SPI+ was implemented), and all eligible patients were provided usual care (evaluation and outpatient referral) in the comparison group (4 VA ED where SPI+ was not implemented).	Treatment with SPI+ vs usual care
JHNEBP Level of Evidence Level IIA	Statistical Analyses	Results	Strengths		Weaknesses	DV
	t tests for quantitative measures and Pearson chi-square tests for categorical measures.	SPI+ is associated with about 50% fewer suicidal behavior and increased behavioral health treatment engagement (more than double the odds) following ED discharge for suicide-related concerns.	1. Clearly defined purpose. 2. Relatively easy to replicate		1. Not a randomized clinical trial. 2. Usual care varied between sites/not standardized. 3. Patients admitted to inpatient (High-risk patients) units were not included. 4. Predominantly (88%) male 5. Lower number of eligible patients in the comparison group	Patients response to SPI+ vs response to usual care
Stanley et al., 2016	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	Emergency departments (EDs) are often the primary contact point for suicidal individuals. The post-ED visit period is a high suicide risk time. To address the need for support during this time, a novel intervention was implemented in five Department of Veterans Affairs medical center EDs. This study assessed the acceptability and perceived usefulness of the combined SAFE VET (Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment) which is a combined Safety Planning Intervention (SPI) with structured follow-up and monitoring (SFU) by telephone.	A combined SPI-SFU intervention will provide patients with an effective and useful crisis management tool.	Qualitative Interviews for demonstration projects.	100 participants completed a semi structured interview.	A convenience sample of SAFE VET participants was developed by contacting participants at random from the list of participants enrolled from February 2010 to May 2012 (that is, they agreed to participate in the project prior to receiving the intervention) at two project sites (Manhattan and Philadelphia). Participants who presented to the ED for a suicide-related concern but who did not require psychiatric hospitalization were eligible to participate in the demonstration project.	Safety Planning Intervention (SPI), Structured Follow-up and monitoring (SFU) via telephone, and the combination of SPI-SFU (SAFE VET).
JHNEBP Level of Evidence Level IIIB	Statistical Analyses	Results	Strengths		Weaknesses	DV
	Themes were summarized with descriptive analysis. Coders were trained on the coding strategy and demonstrated good interrater reliability (SPI questions, $\kappa=.82$, $p<.001$; SFU questions, $\kappa=.87$, $p<.001$; and SAFE VET questions, $\kappa=.81$, $p<.001$). Data were analyzed with SAS software, version 9.2.	Most participants found the SAFE VET intervention (SPI and SFU combined) useful in mitigating suicide risk (very useful, N=55, 55%; fairly useful, N=38, 38%; and neutral, N=7, 7%) and in increasing the likelihood of attending follow-up mental health appointments (very helpful, N=33, 33%; and fairly helpful, N=44, 44%). The overwhelming majority (N=99, 99%) found the SAFE VET intervention very acceptable, reporting that they would recommend it to a friend in crisis.	This study specifically looks at mitigating suicide risk in Veterans using evidence-based interventions (SPI and SFU) that have been shown to be highly effective in identifying and reducing suicide risk.		Sample size. Also, results from the ongoing controlled trials are necessary to confirm that this intervention is more effective than usual care. Lastly, further research is required to determine whether ED staff would be able to successfully implement the intervention given other job responsibilities.	Acceptability, usefulness, and helpfulness of the combination of SPU and SFI (SAFE VET) in mitigating suicide risk and fostering treatment engagement

Bryan et al., 2017	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	To evaluate the effectiveness of crisis response planning for the prevention of suicide attempts over a 6 month period among AD soldiers compared to supportive counseling with a verbal contract for safety.	1. Crisis response planning would be significantly better than contract for safety in reducing SI/SA. 2. Enhanced crisis response planning (clarification on reasons for living) would be significantly better than standard crisis response plan and contract for safety	Randomized clinical trial involving 3 groups. 1. Contract for safety (n=32) was considered "treatment as usual". 2. Crisis response plan (n=32). 3. Enhanced crisis response plan (N=33) Each group was assessed for the incidence of SA, SI, and mental health service utilization during the 6 month period	97 AD U.S. Army personnel with active SI or lifetime history of SA that voluntarily presented for emergency behavioral health evaluation at Ft. Carson, CO.	162 soldiers met criteria (SI/Lifetime SA) 65 declined to participate, resulting in 97 participants separated into 3 groups using a computerized randomization program.	Contract for safety (TAU), Crisis response plan (CRP), and Enhanced Crisis Response Plan (E-CRP).
JHNEBP Level of Evidence Level IIB	Statistical Analyses	Results	Strengths	Weaknesses	DV	
	SA in each treatment group was calculated using Kaplan-Meier method. Longitudinal mixed effects models were used to determine efficacy on severity of SI and follow-up mental health care utilization.	Statistically significant difference between crisis response planning (CRP) and contracts for safety groups (CFS). CRP was 76% less likely to attempt suicide during follow up than CFS group. CRP was associated with a faster decline in SI and fewer inpatient hospitalization days than CFS.	CRP is more effective than CFS in preventing SAs. Study shows intervention that reduces suicidal behavior that is easy to implement and can be performed in a wide range of settings. CRP has been largely based on clinicians beliefs about effectiveness and now has data to support its use.	Insufficient power to detect differences in the two crisis response plans. Larger samples needed to determine the effects of CRP various components and if enhanced CRP increases magnitude of effect.	Suicide attempts, suicidal ideation, & mental health service utilization.	
Kayman et al, 2015	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	Individual interviews were conducted and analyzed to learn about the engagement of suicidal veterans in safety planning.	This pilot study was conducted to address the knowledge gap concerning a veteran's opinion on safety planning	PHENOMENOLOGICAL study. Twenty suicidal veterans who had recently constructed safety plans were recruited at two VA hospitals. In semi structured interviews, they discussed how they felt about constructing and using the plan and suggested changes in plan content and format that might increase engagement.	20 veterans	All participants were veterans who, as part of their treatment for suicidal behavior, had a safety plan.	two semi structured interviews, within days of the safety plan and approx. 1 month follow-up
JHNEBP Level of Evidence Level III	Statistical Analyses	Results	Strengths	Weaknesses	DV	
	Narrative analyses	The veterans' experiences varied widely, from reviewing plans often and noting symptom improvement to not using them at all and doubting that they would think of doing so when deeply depressed.	Authors provided meaningful lived experience with veterans. The findings address potential improvements to safety planning implementation from the perspective of the user.	This was a small, exploratory project that elicited a thought-provoking variety of opinions, beliefs, emotions, and experiences. Confidence in the findings would be greater if the participants had completed a second follow-up interview at 6 months and if the investigators had conducted the study in more than one VA regional network.	Categorical collection of perception in: perceptions concerning plan construction, expectation for plan utility, reported experience with the plan, and barriers & facilitators to using the plan	

Zonana et al, 2017	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV	
	To evaluate the impact of safety plans on patient engagement in an outpatient mental health clinic.	Can safety plans lead to improvement in utilization of care and patient engagement	RCR	N=48	Patients with safety plan documents enrolled in an outpatient mental health clinic 6 months before and 6 months following the creation of a safety plan document.	Safety plans documentation	
	Statistical Analyses	Results			Strengths	Weaknesses	DV
JHNEBP Level of Evidence Level 1A	Paired t test or Wilcoxon signed-rank test	Total outpatient appointments increased by 18% in the 6 months after safety plan implementation (p = 0.19). Total number of hospitalizations significantly decreased following safety plan implementation (p = 0.04) and the total number of crisis calls significantly increased (p = 0.04). There were a total of five suicide attempts in the cohort prior to safety plan completion and one suicide attempt after (p = .10). A 47% decrease in total psychiatric ED visits and a 69% decrease in days spent on an inpatient psychiatric unit were observed (not statistical significance). Outpatient safety planning can improve utilization of healthcare resources and patient engagement.			1. Same group of patients studied pre and post safety plan implementation. 2. Study relatively easy to replicate	1. Not a randomized clinical trial. 2. Low sample size (48). 3. Predominantly (70.8%) female. 4. Generalizability to military population rt conducted in a private outpatient clinic.	Engagement in outpatient mental health clinic, impact on risk behaviors, and utilization of care
Ghahram anlou-Hol lowa, 2014	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV	
	The primary aim of this study is to evaluate the efficacy of Safety Planning Intervention (SPI) in comparison to Enhanced Usual Care (E-CARE) for psychiatrically hospitalized suicidal military personnel and family members	Individuals randomized to the SPI condition in comparison to those assigned to the E-CARE condition are expected to demonstrate significantly reduced levels of avoidant and impulsive problem solving and increased appropriate help-seeking attitudes at one and six months following discharge.	This study uses a randomized controlled trial (RCT) design to compare the efficacy of SPI versus E-CARE. Blinded follow-up assessments are conducted at one and six months following discharge from the hospital.	Based on a power analysis a total of 218 individuals are expected to be recruited for this study.	Patient is either a U.S. military service member or a family member receiving services at the military psychiatric inpatient treatment facility. Age of 18 years old or older. Recently admitted due to recent suicide ideation and/or suicide attempt. and admitted to the military psychiatric inpatient treatment facility. Patients must be able to complete study baseline assessment pref- erably within 48–72 h of being hospitalized.	Treatment with SPI+ vs usual care	
	Statistical Analyses	Results	Strengths		Weaknesses	DV	
JHNEBP Level of Evidence Level 1B	Baseline comparison using T-test/Wilcoxon rank sum test or chi-square tests, depending on whether the outcome is continuous or discrete, to assess if the randomization has been successful for achieving equivalent groups. Bivariate and multivariate analyses will be conducted for the primary and secondary outcomes within and across times.	Longitudinal study	This study is responsive to the mental health care needs of military service members by offering a brief and easy-to administer safety plan intervention designed to enhance psychological coping and health in order to prevent suicide within this vulnerable and high risk group.		Only stable patients were recruited for this study. If a patient is unable to participate in the study because of an acute, unstable, or severe disorder (e.g., acute severe traumatic brain injury). The admitting psychiatrist will determine the level of medical incapacity and degree of cognitive impairment and will not refer patients who are too medically or cognitively impaired to participate.	Patients response to SPI+ vs response to usual care.	

Gamarr et al, 2015	Purpose & Aims	Research Question	Design	Sample	Sampling Plan	IV
	This study aimed to explore the implementation fidelity of safety planning in a regional VHA hospital and examine the associations between safety plan quality and completeness with patient outcomes	Is there an association between the quality and completeness of safety planning for suicide prevention, and subsequent patient outcomes.	For this pilot study, A comprehensive chart review was conducted for patients who were flagged as high risk for suicide. Completeness and quality were coded, as well as information about patient and provider interactions regarding safety plan use	N=200.	This study included veterans identified in the VHA Suicide Prevention and Application Network (SPAN) database, which was obtained by the research team in July 2013. The SPAN database includes VHA patients who were flagged as high risk for suicide within the last 12 months. only the first (or index) safety plan in a patient’s chart was evaluated.	Total completeness Total quality
JHNEBP Level of Evidence Level	Statistical Analyses	Results	Strengths		Weaknesses	DV
	Descriptive statistics were calculated to describe sample characteristics, to assess safety plan fidelity, and to determine the presence or absence of specific providers–patient collaboration and follow-up variables. Six logistic regression analyses were performed analyzing total completeness and total quality as individual predictors of three outcomes: subsequent suicide attempt, subsequent psychiatric hospitalization, and attending four or more outpatient mental health visits.	Safety plans were mostly complete and of moderate quality, although variability existed, particularly in quality. Limited evidence of follow-up regarding safety planning was found in the medical charts. Higher quality was associated with fewer subsequent psychiatric hospitalizations.	This study describes preliminary findings regarding current practice patterns and explores their association with clinical outcomes that are important to consider when treating individuals who are at high risk for suicide. These findings have implications for patient care and for continuing quality improvement of VHA. Additionally, given the widespread use of no-suicide contracts in usual care by non-VHA providers, these findings may suggest the promising utility and feasibility of safety plans as an alternative intervention for suicide prevention in other healthcare settings.		This study was limited to a small sample size. A more thorough, prospective analysis of patient outcomes with a larger sample should be undertaken in future studies to better understand the relationship between safety planning and clinical outcomes in VHA. Also, the method of chart assessment, although clear definitions and decision rules for each rated item increased reliability and rater agreement.	Subsequent suicide attempts, subsequent hospitalizations, and attending four or more outpatient visits.

EVALUATOR: _____

CHART REVIEW # _____

SAFETY PLANNING CHART AUDIT CHECKLIST

RULES		
1. A Safety Plan should be developed following a risk assessment for patients, during which the clinician obtains information needed to complete the Safety Plan. 2. The system considers both the completeness and quality of a Safety Plan. 3. Find the patient's MOST RECENT suicidal/homicide Risk Assessment on file (the patient may not have one). 4. Under this scoring system, Safety Plan scores could range from 0 - 18. 5. <u>Completeness (up to 18)</u> • One point is awarded for each item that is completed. • One point is removed for every completed item that is not appropriate for the veteran. 6. <u>Quality (18 minus x)</u> • Items on the Safety Plan are compared with responses in the most recent suicide/homicide Risk Assessment in the veteran's chart. • One point is removed for every suicide means identified in the plan that was not addressed in means restriction (Step 6). • One point is removed for every coping strategy that brings patients closer to lethal means. • One point is removed for every time means used from previous suicidal attempts are not used (Step 6). • One point is removed for every time firearm is not addressed given the high rate with which firearms are used to die by suicide (Step 6). • One point is removed every time items are deemed poor quality (i.e. conflicted with other information in the safety plan) or seemed unsafe/nonsensical (i.e. going for a drive when the patient verbalized a suicide plan of driving off the road). 7. If the patient DOES NOT have a suicide/homicide risk assessment on file. • SPs can still be scored utilizing the same rules without a risk assessment.		
Does the patient have a suicide/homicide risk assessment on file? ☐ YES ☐ NO		
Does the patient have a previous history of suicidal attempt? ☐ YES ☐ NO		
Describe the suicidal attempt:		
☐ STEP 1: WARNING SIGNS. Includes thoughts, images, cognitions, moods, or behaviors that indicate an impending suicidal crisis (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
☐ STEP 2: INTERNAL COPING STRATEGIES. Include skills or behaviors the individual can employ on their own (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
☐ STEP 3: SOCIAL CONTACTS AND LOCATIONS THAT SERVE AS DISTRACTIONS. Include individuals that the at-risk person can talk to about neutral topics to provide a distraction (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
☐ STEP 4: CONTACT FAMILY MEMBERS OR FRIENDS THAT MAY OFFER HELP TO RESOLVE THE SUICIDAL CRISIS. (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
☐ STEP 5: CONTACT PROFESSIONALS OR AGENCIES FOR HELP. The Veterans' Crisis Line: 1-800-273-TALK, Press 1 (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
☐ STEP 6: REDUCING THE POTENTIAL FOR USE OF LETHAL MEANS. Includes a list of preventative actions taken in advance of a suicidal crisis. This step must address previous suicidal attempts (<i>1 point for each item identified. Total of 3 points</i>)		
1.	2.	3.
*SPCAC based on the article by Green, Kearns, Rosen, Keane, & Marx, 2018.		

Safety Plan Worksheet	
Purpose: Providers and patients complete Safety Plan together, and patients keep it with them	
Step 1. Warning signs (that I might be headed toward a crisis and the Safety Plan should be used):	
1.	
2.	
3.	
4.	
Step 2. Internal coping strategies (things I can do to distract from my problems without contacting another person):	
1.	
2.	
3.	
Step 3. People, places and social settings that provide healthy distraction (and help me feel better):	
1. Name and phone number:	
2. Name and phone number:	
3. Place:	
4. Place:	
Step 4. People I can contact to ask for help (family members, friends and co-workers):	
1. Name and phone number:	
2. Name and phone number:	
3. Name and phone number:	
4. Name and phone number:	
Step 5. Professionals or agencies that can help me during a crisis:	
• Clinician/Agency (Name, phone, pager, emergency contact number) 	
• Clinician/Agency (Name, phone, pager, emergency contact number) 	
• Local Emergency Department (Name, phone number, location/address) 	
• Other (Name, phone, pager, emergency contact number) 	
 Military/Veterans Crisis Line: Dial 800-273-TALK (8255), press 1 for military, or text 838255 or live chat at http://militarycrisisline.net for 24/7 crisis support.	National Suicide Prevention Lifeline: Dial 800-273-TALK (8255) or live chat at https://suicidepreventionlifeline.org for 24/7 crisis support.
Step 6. Making my environment safe (plans for removing or limiting access to lethal means):	
1.	
2.	
3.	
4.	
Step 7. My reasons for living (things that are most important to me and worth living for):	
1.	4.
2.	5.
3.	6.



Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.
 Reference: Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256–264.
 Updated April 2020 by the Psychological Health Center of Excellence.

Safety Plan Worksheet: Brief Instructions for Providers



Providers: Complete semi-structured interview of recent suicidal crisis before proceeding to Step 1
Print copy of completed Safety Plan for patient and place a duplicate copy in medical record

Step 1. Recognizing warning signs

- **Ask patient** "How will you know when the Safety Plan should be used?"
- **Ask patient** "What do you experience when you start to think about suicide or feel extremely distressed?"
- **List warning signs**, including thoughts, images, thinking processes, mood, and/or behaviors, using the patient's own words. (Ex: "I feel really numb," "I think 'Nobody even cares about me,'" "I stop answering calls and texts")

Step 2. Using internal coping strategies

- **Ask patient** "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
- **Ask patient** "How likely would you be able to do this step during a time of crisis?"
- **If doubt about using coping strategies is expressed**, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- **Use a collaborative, problem-solving approach** to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3. Social contacts who may distract from the crisis

- **Instruct patient** to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- **Ask patient** "Who or what social settings help you take your mind off your problems, at least for a little while?" and "Who helps you feel better when you socialize with them?"
- **Ask patient** to list several people and social settings, in case the first option is unavailable.
- **Ask patient** for safe places they can go to be around people, e.g., coffee shop.
- **Remember, in this step, suicidal thoughts and feelings are not revealed to their social contacts.**

Step 4. Contacting family members, friends, caregivers or others who may offer help to resolve a crisis

- **Instruct patient** to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- **Ask patient** "Among your family or friends, who could you contact for help during a crisis?" or "Who is supportive of you and who do you feel you can talk with when you're under stress?"
- **Ask patient** to list several people, in case they cannot reach the first person on the list. Prioritize the list. **In this step, unlike the previous step, patients reveal to their contacts that they are in crisis.**
- **Ask patient** "How likely would you be willing to contact these individuals?"
- **If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.**

Step 5. Contacting professionals and agencies

- **Instruct patient** to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- **Ask patient** "Who are the behavioral health professionals who should be on your safety plan?" and "Are there other health care providers?" **In this step, suicidal thoughts and feelings are discussed with health professionals/agencies.**
- **List names, numbers and/or locations of clinicians, local urgent care services, military service/command or VA suicide prevention coordinator, Military/Veterans Crisis Line and/or National Suicide Prevention Helpline (800-273-TALK [8255]).**
- **If doubt is expressed about contacting health professionals/agencies, identify potential obstacles and problem solve ways to overcome them.**

Step 6. Reducing the potential for use of lethal means

- **Ask patient which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.** Use non-judgmental tone and language with open-ended questions.
- For patients who identify methods with low lethality, clinicians may ask patients to remove or restrict access themselves or with assistance.
- **Restricting the patient's access to a highly lethal method should be done by a designated, responsible person — usually a family member, caregiver, close friend, military command, or the police.**
- Examples: Keep medications locked in a safe place, properly dispose of medications you no longer need, never keep lethal doses of any medication on hand, keep firearms locked in a safe with ammunition stored separately, have a trusted individual temporarily store firearm until safety is re-established.
- Consider prescribing naloxone for patients at risk for opioid overdose (See VA/DoD opioid therapy clinical practice guideline).

Step 7. Remembering reasons for living

- **Ask patient** to list their reasons for living, including answers to the following: "The things that are most important to me and worth living for are:"



Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.
Reference: Stanley, B., Brown, G. K., Karlin, B., Kemp, J., & VonBergren, H. (2008). Safety plan treatment manual to reduce suicide risk: Veteran version. Washington, DC: United States Department of Veterans Affairs.
Updated April 2020 by the Psychological Health Center of Excellence.

Appendix H



Completion Date 24-Aug-2018
Expiration Date 23-Aug-2021
Record ID 28255626

This is to certify that:

Amanda Reed

Has completed the following CITI Program course:

OUUSD P&R Human Research	(Curriculum Group)
Biomedical Investigators and Research Study Team	(Course Learner Group)
1 - Biomedical Investigators	(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w222c974c-3ea5-4b13-a2cc-e82691b7442f-28255626



Completion Date 24-Aug-2018
Expiration Date 23-Aug-2021
Record ID 28255627

This is to certify that:

Amanda Reed

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus)

(Curriculum Group)

GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)

(Course Learner Group)

1 - GCP

(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 24-Aug-2018
Expiration Date 23-Aug-2021
Record ID 28255628

This is to certify that:

Amanda Reed

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)
Responsible Conduct of Research (RCR) (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 10-Sep-2018

Expiration Date 09-Sep-2021

Record ID 28316677

This is to certify that:

Eric Womack

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)

Responsible Conduct of Research (RCR) (Course Learner Group)

1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w96110bcc-22c4-4446-8cbc-24212ab3d9b3-28316677



Completion Date 28-Aug-2018
Expiration Date 27-Aug-2021
Record ID 28316676

This is to certify that:

Eric Womack

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus)

(Curriculum Group)

GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)

(Course Learner Group)

1 - GCP

(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 28-Aug-2018
Expiration Date 27-Aug-2021
Record ID 28316675

This is to certify that:

Eric Womack

Has completed the following CITI Program course:

OUUSD P&R Human Research	(Curriculum Group)
Biomedical Investigators and Research Study Team	(Course Learner Group)
1 - Biomedical Investigators	(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 26-Aug-2018

Expiration Date 25-Aug-2021

Record ID 28320881

This is to certify that:

Sarah Head

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus)

(Curriculum Group)

GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)

(Course Learner Group)

1 - GCP

(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI

Collaborative Institutional Training Initiative

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Completion Date 27-Aug-2018
Expiration Date 26-Aug-2021
Record ID 28325400

This is to certify that:

Sarah Head

Has completed the following CITI Program course:

OUUSD P&R Human Research	(Curriculum Group)
Biomedical Investigators and Research Study Team	(Course Learner Group)
1 - Biomedical Investigators	(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 27-Aug-2018

Expiration Date 26-Aug-2021

Record ID 28320882

This is to certify that:

Sarah Head

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)

Responsible Conduct of Research (RCR) (Course Learner Group)

1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 26-Aug-2018
Expiration Date 25-Aug-2021
Record ID 28319945

This is to certify that:

Olabowale Olaigbe

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus)

(Curriculum Group)

GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)

(Course Learner Group)

1 - GCP

(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 26-Aug-2018

Expiration Date 25-Aug-2021

Record ID 28319946

This is to certify that:

Olabowale Olaigbe

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)

Responsible Conduct of Research (RCR) (Course Learner Group)

1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 26-Aug-2018
Expiration Date 25-Aug-2021
Record ID 28319941

This is to certify that:

Olabowale Olaigbe

Has completed the following CITI Program course:

OUUSD P&R Human Research	(Curriculum Group)
Biomedical Investigators and Research Study Team	(Course Learner Group)
1 - Biomedical Investigators	(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28382877

This is to certify that:

Delanta McCall

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)
Responsible Conduct of Research (RCR) (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28382875

This is to certify that:

Delanta McCall

Has completed the following CITI Program course:

OUUSD P&R Human Research	(Curriculum Group)
Biomedical Investigators and Research Study Team	(Course Learner Group)
1 - Biomedical Investigators	(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

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Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28382876

This is to certify that:

Delanta McCall

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus)

(Curriculum Group)

GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)

(Course Learner Group)

1 - GCP

(Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI

Collaborative Institutional Training Initiative

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**OFFICE OF RESEARCH**

4301 JONES BRIDGE ROAD

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NOTICE OF PROJECT APPROVAL

Change Number: Original

VPR Site Number: GSN-61-11591
Principal Investigator: Fox, Amanda
Department: Graduate School of Nursing
Project Type: Student
Project Title: A Joint Force Evaluation of the Behavioral Health Team's Documentation of Safety Plan Interventions
Project Period: 11/5/2020 to 4/30/2021

Assurance and Progress Report Information:

<u>Name</u>	<u>Sup</u>	<u>Approval Type</u>	<u>Status</u>	<u>Approved On</u>	<u>Forms Received</u>
Progress Report	0			To be Submitted	N/A

Remarks:

This Notice Of Project Approval has been reviewed and approved. Please remember that you must submit a final Progress Report (Form 3210) upon completion of this project.

Questions regarding this approval should be directed to the following person in the Office of Research:
Sharon McIver, (301) 295-9814.

Mark G. Kortepeter, MD, MPH
FACP, FIDSA, FASTMH
COL (R) MC US Army
Vice President for Research
Uniformed Services University of the Health Sciences

Date

cc: File

Dr. Kennett Radford

Laura, Taylor

**OFFICE OF RESEARCH**

4301 JONES BRIDGE ROAD

BETHESDA, MARYLAND 20814

PHONE: (301) 295-3303; FAX: (301) 295-6771

NOTICE OF PROJECT APPROVAL

Change Number: Original

USU Project Number: GSN-61-11591
Principal Investigator: Fox, Amanda
Department: Graduate School of Nursing
Project Type: Student
Project Title: A Joint Force Evaluation of the Behavioral Health Team's Documentation of Safety Plan Interventions
Project Period: 11/5/2020 to 4/30/2021

Type of Action:**Project Approval**

Approvals**Specialist Review:** _____**Director Review:** _____

Notes

Appendix J



DEPARTMENT OF THE ARMY
WILLIAM BEAUMONT ARMY MEDICAL CENTER
5005 N PIEDRAS STREET
EL PASO, TX 79920-5001

MCHM-DQS

30 October 2020

MEMORANDUM FOR LTC Deanna Sheets, DNP, Education Department, William Beaumont Army Medical Center (WBAMC), 5005 N. Piedras Street, El Paso, TX 79920

SUBJECT: Not Research Status Determination

STUDY TITLE: A Joint Force Evaluation of Mental Health Team's Documentation of Safety Plans in Outpatient Management of Patients at Risk for Suicide

REFERENCE: #21-05

REVIEW TYPE: Determination

ACTION: CONCURRENCE WITH NOT RESEARCH STATUS DETERMINATION

DETERMINATION DATE: 30 October 2020

1. This memo is in response to your request for a "not research" determination review for the above-referenced project.
2. A William Beaumont Army Medical Center (WBAMC) Determination Official has reviewed your proposed project and has concurred with the "not research" determination issued by the Naval Medical Center Portsmouth on 26 October 2020 for this project. The WBAMC Determination Official concurs that your project does not meet the definition of research as defined under 32 CFR 219.102(l).
3. Because this project has been determined to be "not research," it is not subject to further review by the Human Research Protections Program or the Institutional Review Board (IRB). This determination should not be construed as approval to initiate the project. Other institutional approvals may be required and should be coordinated through your department.
4. Any collection of information via surveys as defined by DoDI 8910.01 must comply with DoDI 1100.13 "DoD Surveys." It is the responsibility of the Project Lead to ensure that any additional reviews and approvals specific to these regulations are obtained. Please provide a copy of the approval documentation to the WBAMC HRPP Office, if applicable to your study.

Clinical Investigation Department, Naval Medical Center Portsmouth

620 John Paul Jones Circle, Portsmouth, VA 23708 (757) 953-5939 Fax (757) 953-5298, DSN 377-5939



Thomas S. Rieg, PhD
Research Director

Kersten N. Wheeler, MS
Deputy Director
Division Head,
Research Subjects Protection

June G. Brockman, BA
Division Head,
Research Resources

Kamala J. Rapp-Santos, DVM
Major, VC, USA
Division Head,
Laboratory Animal Medicine

October 26, 2020

From: Deputy, Clinical Investigation Department
To: CDR Meedeessa Morgan, NC, USN

SUBJ: DETERMINATION OF NOT RESEARCH

1. Your project titled NMCP.2020.0136: "A Joint Force Evaluation of Mental Health Team's Documentation of Safety Plans in the Outpatient Management of Patients at Risk for Suicide" has been evaluated by an Exemption Determination Official (EDO). This project DOES NOT meet the definition of RESEARCH in accordance with 32 CFR 219.102 and DoDI 3216.02.
2. An EDO must review any study design changes that may change the scope of the project to ensure that they do not affect this determination. All modifications must be submitted in EIRB.
3. Projects that do not require IRB approval are not eligible for Clinical Investigation Department travel funds.
4. Any publication resulting from this project must be cleared through the publication clearance process, which is required for all works presented or published outside of your command. Investigators at NMCP may obtain information from the CID SharePoint page. Investigators from other commands should contact their local Public Affairs Office.
5. Any questions may be directed to Sarah C. Wilder Hussain, [REDACTED]. Please include your project title and IRB number in all correspondence with the IRB Office.

[REDACTED]
K. N. WHEELER

"FIRST AND FINEST IN RESEARCH SUPPORT"

Research with Human Subjects and Exemption Determination Form**Reviewer Name:** Katherine Silz-Carson, Ph.D.**PI Name:** Maj. Kellie Bond**Project Title:** A Joint Force Evaluation of Mental Health T**Protocol Number:** FAC20210014N**Activity Summary:**

Please provide a summary of the activity that is being reviewed, paying particular attention to any aspects of the activity that MAY constitute research with human subjects.

The purpose of the study is to evaluate whether Colorado Springs and other sites' mental health clinics are adhering to the 2019 VA/DoD Clinical Practice Guidelines for patients at risk for suicide. Researchers will conduct a patient record review to determine adherence. The team will pull data from AHLTA, and will not pull any personally identifiable information from the system. Interventions provided to providers (e.g. a standardized safety plan worksheet) will depend on the outcome of the records review.

To the reviewer: *If the submission does not provide sufficient information for you to answer any of the questions below, contact the researcher for more information.*

Step 1 – Activities not deemed to be research: Is the activity any of the following? (Indicate which category applies):

- ☐ Scholarly and journalist activities (e.g. oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.
- ☐ Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. (See 32 CFR 219.102(l)(2) for limitations on these activities.)
- ☐ Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.
- ☐ Authorized operational activities (as determined by the Department of Defense) in support of intelligence, homeland security, defense, or other national security missions.

If any of the above categories apply, STOP. Proceed to page 5 to complete your determination and rationale.

Step 2: Is the activity research?

- YES** Is the activity a systematic investigation, including research development, testing, and evaluation?
- NO** Is the activity designed to develop or contribute to generalizable knowledge?

If "Yes" to BOTH questions, the activity IS research. Continue to Step 3 below.

If "No" to either question the activity is NOT research. Proceed to page 5 to complete your determination and rationale.

Step 3: Does the research involve human subjects?

Step 3a: What kind of information will the investigator(s) be using?

Choose Does the research involve living individuals?

Choose Will the investigator(s) obtain information or biospecimens about the individuals?

If "Yes" to both questions, proceed to step 3b. The research MAY involve human subjects.

If "No" to either question the activity does not involve human subjects. Proceed to page 5 to complete your determination and rationale.

Step 3b: What information will the investigators have, and how will they obtain and use it?

Choose Will the investigators obtain information or biospecimens through intervention or interaction with the individual, and use study, or analyze the information or biospecimens?

Choose Will the investigator obtain, use, study, analyze or generate identifiable private information or identifiable biospecimens?

If "Yes" to either question, the research DOES involve human subjects. Go to section 4 to determine which exemption category (if any) applies.

If "No" to BOTH question the activity is NOT research with human subjects. Proceed to page 5 to complete your determination and rationale.

Step 4 - Exemption Categories: Indicate which of the categories and subcategories (if applicable) applies.

☐

(1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness or the comparison among instructional techniques, curricula, or classroom management methods.

☐

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, Aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met (*Indicate which criterion applies*):

☐

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

☐

(ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or

- ☐ (iii) The information obtained is recorded by the investigator in such a manner that the identity of the subjects can readily be ascertained, directly or through identifiers linked to the subjects.

If criterion (iii) applies, refer the study to the IRB for a limited IRB review.

- ☐ (3) Research involving benign behavioral interventions (interventions that are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing) in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if one of the following criteria is met (*Indicate which criterion applies*):

- ☐ (A) The information obtained is recorded by the investigator in such a manner that the identity of the subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
- ☐ (B) Any disclosure of the subjects' responses outside the research would not place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing employability, educational advancement, or reputation; or
- ☐ (C) The information obtained is recorded by the investigator in such a manner that the identity of the subjects can readily be ascertained, directly or through identifiers linked to the subjects.

If criterion (C) applies, refer the study to the IRB for a limited IRB review.

Choose Does the study involve deception about the nature or purposes of the research?

If the study involves deception, the following criterion must also be satisfied in order for the study to be eligible for exemption.

Choose The research involves deceiving subjects regarding the nature or purposes of the research, and the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that s/he will be unaware of or misled regarding the nature or purposes of the research.

The following criterion MUST also be satisfied in order for the study to be eligible for exemption (indicate whether it applies):

Choose The subject prospectively agrees to the intervention and information collection.

- ☐ (4) Secondary research for which consent is not required: Secondary research using identifiable private information or identifiable biospecimens, if at least one of the following criteria is met (*indicate which criterion applies*):

- ☐ (i) The identifiable private information or identifiable biospecimens are publicly available;

☐ (ii) The information is recorded in such a manner that the identity of the subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify the subjects;

☐ (iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information regulated under HIPAA (45 CFR 160 and 45 CFR 164, subparts A and E) for the purposes of "health care operations" or "research" as defined in 45 CFR 160.501 or for "public health activities and purposes" as described under 45 CFR 512(b); or

☐ (iv) The research is conducted by, or on behalf of, a Federal department or agency using government-collected information obtained for nonresearch activities if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with the E-Government Act of 2002, if the identifiable private information collected, used, or generated will be maintained in systems of records subject to the Privacy Act of 1974, and (if applicable), the information used was collected subject to the Paperwork Reduction Act of 1995. (*Note: Administrative data collected and maintained by USAFA is compliant with these regulations.*)

☐ (5) Research and demonstration projects that are conducted or supported by a Federal department or agency that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under these programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs.

☐ (6) Taste and food quality evaluation and consumer acceptance studies if wholesome foods Without additives are consumed, or if a food is consumed that contains a food ingredient, agricultural chemical, or environmental contaminant at or below the level and for a use found to be safe by the FDA or approved by the EPA or the Food Safety and Inspection Service of the USDA.

☐ (7) Storage and maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use.

If exemption category (7) applies, refer the study to the IRB for limited IRB review.

☐ (8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or biospecimens for secondary research use.

If exemption category (8) applies, refer the study to the IRB for limited IRB review.

Reviewer Determination:

- ☒ This activity is not research or it is not research involving human subjects.
- ☐ This activity is research involving human subjects and is exempt under category Choose
- ☐ This activity is research involving human subjects that is exempt under category Choose and requires a limited IRB review. This study is referred to the IRB for limited IRB review.
- ☐ This activity is research involving human subjects that is not eligible for exemption. This study is referred to the IRB for a full board review.

Reviewer Rationale for Determination:

Provide a rationale for the determination in the space below, focusing on specific information from the research protocol and the relevant regulatory criteria in the definitions and exemption category explanations from the Common Rule.

The activity is intended for program improvement purposes only. Because there will be no effort to use the results of the activity to contribute to generalizable knowledge, the activity does not satisfy the Common Rule's definition of research (32 CFR 219.102(l)).

Reviewer Signature

Date: 27 Jan 2021

Appendix K

PAO Clearance

Appendix L



Appendix G: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled:

A Joint Force Evaluation of the Behavioral Health Team's Documentation of Safety Plan in the Outpatient Management of Patients Identified as High Risk for Suicide

was completed at: USAFA, Fort Bliss, and NMRTC Portsmouth

by the following student(s):

<i>(type student name)</i>	<i>(signature)</i>	<i>(date)</i>
Amanda Fox		03/17/2021
Olabowale Olaigbe		03/19/2021
Sarah Head		03/19/2021
Eric Womack		03/19/2021
Delanta McCall		03/19/2021

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>
Senior Mentor: <u>Lt Col Regina Owen</u>		3/29/2021
Team Mentor: <u>LTC Deanna Sheets</u>		3/25/2021
Team Mentor: <u>Maj Kelly Bond</u>		3/29/2021
Phase II Site Director: <u>CDR Meedeessa Morgan</u>		3/29/2021

For RNA Students only - add the following additional signature for final verification of project completion:

<i>(type name)</i>	<i>(Signature)</i>	<i>(Date)</i>
RNA Project Director		