Measure ID: PP12

Measure Name/Title

Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk

1. **Descriptive Information**

1.1 Measure Type

Process

1.2 National Quality Strategy (NQS) domain

Effective Clinical Care

1.3 Meaningful Measure Area

Prevention, Treatment, and Management of Mental Health

1.4 Brief Description of Measure

This measure assesses the percentage of adults aged 18 and older with a mental and/or substance use disorder with suicidal ideation or behavior symptoms (based on results of a standardized assessment tool) or increased suicide risk (based on the clinician's evaluation) for whom a suicide safety plan is initiated, reviewed, and/or updated in collaboration between the patient and their clinician.

2. Measure Specifications

2.1 Data Dictionary, Code Table, or Value Sets

See Appendix A.

2.2 For an instrument-based measure

See Appendix B.

2.3 Numerator Statement

[Note: This is a single measure with two rates, and therefore maintains two numerators].

NUMERATOR 1:

Individuals in the target population for whom a complete suicide safety plan is initiated, reviewed, or updated in collaboration between the individual and their clinician at the time the suicidal ideation behavior or risk is identified (concurrent or within 24 hours of index clinical encounter), during the measurement period.

NUMERATOR 2:

Individuals in the target population for whom a suicide safety plan is initiated, reviewed, or updated in collaboration between the individual and their clinician at the time the suicidal ideation, behavior or risk is identified (concurrent or within 24 hours of clinical encounter) (i.e., individuals who satisfy Numerator 1) AND reviewed and updated within 120 days after the index clinical encounter, during the measurement period.

2.4 Numerator Details

Suicide safety plan (see Appendix D) is a brief intervention that involves the patient with suicidal ideation, behavior or risk and their clinician working in collaboration to identify and document: a written list of warning signs, internal coping strategies the patient can use to stay safe without involving others, sources of support (including access to professional services), and ways to make their environment safe. The plan must include the following six steps where the provider helps the patient to:

- Recognize the warning signs of the suicidal crisis
- Learn how to employ internal coping strategies without needing to contact another person
- Understand the need and benefits of socializing with family members or others who may offer distraction from the suicidal crisis
- Contact family members or friends who may help them to resolve the suicidal crisis
- Contact mental health professionals or agencies
- Identify ways to make their environment safe (e.g., reduce their access to lethal means such as firearms)

Measurement Period: A 16-month period, starting 4 months prior to the measurement year through the 12 months of the measurement year.

2.5 Denominator Statement

Individuals aged 18 and older with a mental and/or substance use disorder presenting with suicidal ideation or behavior symptoms (based on results of a standardized assessment tool) or suicide risk (based on the clinician's evaluation) during the denominator identification period.

2.6 Denominator Details

Denominator Identification Period: The denominator identification period is the period in which individuals can have an encounter where they are assessed for suicidal ideation or behavior symptoms (based on results of a standardized assessment tool) or suicide risk (based on the clinician's evaluation), and eligible for the measure's denominator. The denominator identification period is 12 months, starting 4 months prior to the measurement year through the first 8 months of the measurement year. If there are multiple assessments during the denominator identification period, the assessment that will be counted as the index is the first assessment completed during the denominator identification period.

Age Range: Individuals aged 18 and older as of the date of the index clinical encounter (where suicidal ideation or behavior symptoms, or suicide risk, was identified).

Suicidal ideation and behavior assessment: Suicidal ideation and behavior should be assessed using a standardized assessment tool such as the Columbia Suicide Severity Rating Scale (C-SSRS) – Screen Version Recent. The CSSRSScreen Version Recent is a 6-item patient self-reported tool that enquires about wish for death, thoughts of suicide, suicidal thoughts with method without specific thoughts or intent, suicidal intent without and with specific plan, and suicide behavior. The intensity of the ideation is rated on a 5-point scale (1=least severe to 5=most severe) using the ideation intensity items from the Since Last Visit (January 14, 2009) version of C-SSRSS. A non-zero score on the CSSRSScreen Version Recent indicates the need to initiate the Suicide Safety Plan and hence defines the denominator.

Other patient-reported assessment tools that qualify for this measure include, but are not limited to:

Patient Health Questionnaire (PHQ-9) - Item 9: The PHQ-9 is a routinely used scale in behavioral health and primary care. Item 9 of the instrument asks whether the patient has thoughts that they would be better off dead, or of hurting themselves.

Suicide risk assessment: The Clinician Rating of Potential Suicide Risk (CRPSR) is a single item clinician-rated tool that was developed and tested during the DSM-5 Field Trials. The assessment tool includes a listing of risk factors for suicide and a description of a what very high-risk patient might look like. The clinician is asked to consider the list of risk factors and the description of a very high-risk patient in their clinical evaluation of the patient, and to rate the patient's risk for suicide and the need for suicide prevention as part of the patient's current clinical management. A non-zero score on the CSSRS indicates the need to initiate the Suicide Safety Plan. The CRPSR item is rated on a 5-point scale (See Appendix B):

- 0 = Lowest Concern (no prior or current concern about suicidal behavior)
- 1 = Some Concern (prior history of suicidal ideation or behavior but preventing suicidal behavior is not a focus of the current clinical management of the patient)
- 2 = Moderate Concern (preventing suicidal behavior is a part of current clinical management but less important than other components of the treatment plan)
- 3 = High Concern (preventing suicidal behavior is one of the main goals in the current clinical management of the patient)
- 4 = Imminent Concern (preventing suicidal behavior is the most important goal in the current clinical management of the patient)

Other clinician rated assessment tools that qualify for this measure include, but are not limited to: Suicide Assessment Five-step Evaluation & Triage (SAFE-T), SAFE-T Protocol with CSSRS(Columbia Risk & Protective Factors) Lifetime/Recent, CSSRS(Columbia Risk & Protective Factors) Lifetime/Recent

2.7 Denominator Exclusions

The patient has a diagnosis of an incapacitating mental health disorder during the denominator identification period or patient death occurred during the measurement period.

2.8 Denominator Exclusion Details

Patients will be excluded from the denominator if:

1. The patient has a documented diagnosis of any mental health condition with a high likelihood of impaired functional capacity, motivation, and/or altered ability to use an assessment tool during denominator identification period or in the 12 months prior.
    a. *Rationale: These conditions can impact the accuracy of results of validated tools.*
        i. F00-09: Mental disorders due to known physiological conditions (e.g., delirium, dementia)
        ii. F70-79: Intellectual disabilities
        iii. F80-89: Pervasive and specific developmental disorders
2. Patient deceased during the measurement period

2.9 High Priority Status

No

2.10 Type of Score

rate/proportion

2.11 Telehealth

Yes

2.12 Number of performance rates

2

2.13 Traditional vs. inverse measure

Traditional

2.14 Interpretation of Score

Better quality = higher score

2.15 Calculation Algorithm/Measure Logic

STEP 1: Initial denominator population. Identify individuals aged 18 and older with any suicidal ideation, behaviors, or suicide risk based on results of a standardized patient reported or clinician-rated tool with an encounter during the denominator identification period (Sept 3 (year prior)-Sept 2) (section 3.8 and 3.9).

STEP 2: Identify exclusions from denominator. For all individuals included in the denominator in Step 1 above, identify all individuals that meet the exclusion criteria as defined in sections 3.10 and 3.11.

STEP 3: Identify final denominator population. For all individuals included in the denominator in Step 1 above, identify and remove all individuals that meet the exclusion criteria as defined in sections 3.10 and 3.11.

STEP 4: Final numerator population. Determine the number of patients who meet performance criteria defined in section 3.6 and 3.7:

Numerator 1- Complete suicide safety plan is documented as initiated, reviewed, or updated in the medical/health record.

Numerator 2- Complete suicide safety plan AND a review and update to the suicide safety plan is documented in the medical/health record within 120 days of the initial suicide safety plan being created.

STEP 7: Calculate the performance scores for the two measure rates for the given measurement period as follows:

Performance Score Rate 1 = Final Numerator 1 Population (Step 4) ÷ Final Denominator Population (Step 3).

Performance Score Rate 2 = Final Numerator 2 Population (Step 4) ÷ (Final Denominator Population (Step 3).

For the current measure, calculations are performed at the provider and site level. A given patient may see multiple providers in a single day, all of whom may utilize the patient-reported measure data in care. All providers associated with the index patient encounter are credited toward measure performance.

2.16 Data Source:

- patient medical records (i.e., paper-based or electronic)
- registries
- patient-reported data and surveys

2.17 Data Source or Collection Instrument

Electronic patient medical record data, which included results of patient-reported outcome assessments, as well as claims data, from three sources were used in the testing of this process measure.

2.18 Data Source or Collection Instrument (Reference) (NQF Submission Form S.19.)

Suicide Safety Plan

Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice, 19(2), 256-264. doi:10.1016/j.cbpra.2011.01.001

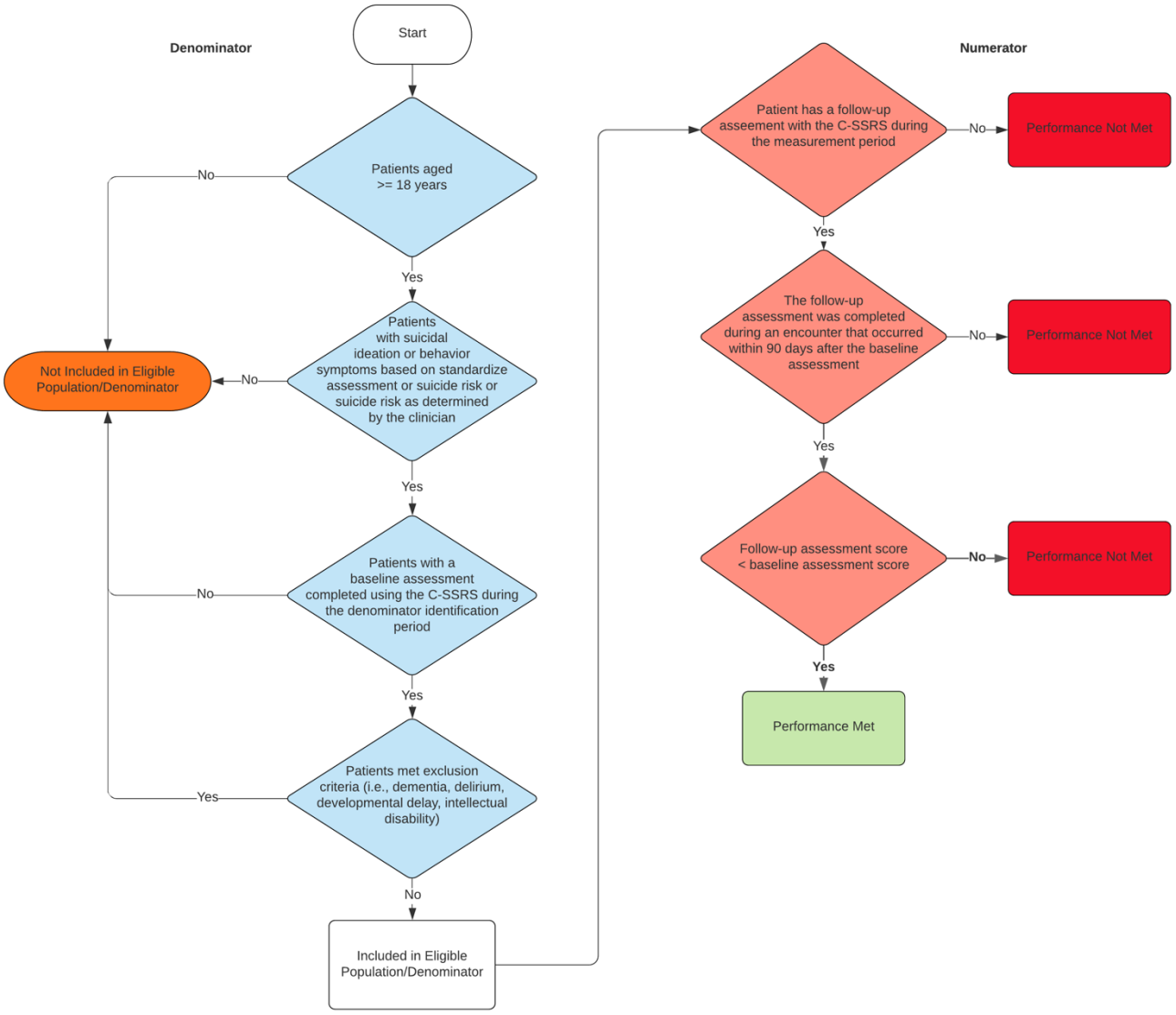
2.19 Level of Analysis:

- individual clinician
- group/practice

2.20 Care Setting

- clinician office/clinic
- behavioral health: Outpatient

Figure 1. Measure specification logic



Appendix A. Data Elements

Data Elements and Validity Testing Results

Data Element & Description	Validity Test Logic
gender Patient's sex	gender %in% c("MALE" "FEMALE")
signed_date Suicide safety plan date	signed_date >= "2019-09-01" & signed_date <= 2020-12-31
servicedate Encounter date	servicedate >= "2019-09-01" & servicedate <= 2020-12-31
ageatservice Age at encounter, derived from date of birth – encounter date	ageatservice >= 18 & ageatservice <= 120
cpt_code Encounter CPT code	cpt_code %in% cpt_codes [codes from denominator criteria]
phq_date PHQ-9 date	phq_date >= "2019-09-01" & phq_date <= 2020-12-31
phq9_9 PHQ-9 item 9 response	phq9_9 %in% c("Yes", "No)
completed_date PHQ-9 completion date	completed_date >= "2019-09-01" & completed_date <= 2020-12-31
user_decision Clinician's decision as to patient's suicide risk	user_decision %in% c("Enroll", "Do not enroll", "Unenroll", "Keep in pathway")
si_wish_dead_month CSSRS item 1	si_wish_dead_month %in% c("Yes, No)
si_wish_dead_visit CSSRS item 1	si_wish_dead_visit %in% c("Yes, No)
si_nonspec_active_month CSSRS item 2	si_nonspec_active_month %in% c("Yes, No)
si_nonspec_active_visit CSSRS item 2	si_nonspec_active_visit %in% c("Yes, No)
si_active_no_int_month	si_active_no_int_month %in% c("Yes, No)

Data Element & Description	Validity Test Logic
CSSRS item 3	
si_active_no_int_visit CSSRS item 3	si_active_no_int_visit %in% c("Yes, No)
si_active_no_plan_month CSSRS item 4	si_active_no_plan_month %in% c("Yes, No)
si_active_no_plan_visit CSSRS item 4	si_active_no_plan_visit %in% c("Yes, No)
si_active_plan_month CSSRS item 5	si_active_plan_month %in% c("Yes, No)
si_active_plan_visit CSSRS item 5	si_active_plan_visit %in% c("Yes, No)
begin_date ICD-10 diagnosis date from problem list	begin_date >= "2019-09-01" & begin_date <= 2020-12-31
icd10_code ICD-10 diagnosis code	str_detect(icd10_code, "^F")
loc_type Encounter location type	loc_type == "Outpatient"

Appendix B. Instruments

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) IDEATION INTENSITY ITEMS

Frequency

How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration

When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability

Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others
(2) Mostly to get attention, revenge or a reaction from others
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(0) Does not apply

Current Concern about Potential Suicide Behavior

Clinician Rating of Current Concern About Potential Suicide Behavior: **Note: The items below should serve as a guideline of minimum factors to be considered when determining your concern about the patient's potential risk for suicidal behaviors.**		
Is there evidence of:		
L ONG-TERM FACTORS:		
1. Any history of suicide attempt?	❑ No	❑Yes
2. Any history of mental illness?	❑ No	❑Yes
3. Any history of physical or sexual abuse?	❑ No	❑Yes
4. Long-standing tendency to lose temper or become aggressive with little provocation?	❑ No	❑Yes
5. Chronic severe pain or disabling illness?	❑ No	❑Yes
6. Past suicidal behavior in family or associate?	❑ No	❑Yes
RECENT EVENTS (within the past 3 months)		
1. Recent significant loss?	❑ No	❑Yes
2. Recent psychiatric admission or discharge?	❑ No	❑Yes
3. Recent first diagnosis of any psychiatric disorder?	❑ No	❑Yes
4. Recent worsening of depressive symptoms or increase in alcohol abuse?	❑ No	❑Yes
CURRENT STATUS (within the last week)		
1. Current preoccupation and plans for suicide?	❑ No	❑Yes
2. Current psychomotor agitation or marked anxiety?	❑ No	❑Yes
3. Current prominent feelings of hopelessness?	❑ No	❑Yes
4. Currently living alone?	❑ No	❑Yes
VERY HIGH RISK might include: • **Current abnormal mental state with agitation** • **Current depression or other mood disorders with comorbid aggression, increased impulsivity, severe anxiety, or alcohol or benzodiazepine use** • **Preoccupation and plans for suicide** • **Current major loss or anticipated loss** • **Recent discharge from the hospital after treatment for a suicidal state with residual ideation** • **Availability of lethal means**		
Clinician's Rating of the level of concern about potential suicidal behavior:		
What is your level of concern about potential suicidal behavior for this patient? ❑ Lowest concern (no prior or current concern about suicidal behavior) ❑ Some concern (prior history of suicidal ideation or behavior, but preventing suicidal behavior is not a focus of the current clinical management) ❑ Moderate concern (preventing suicidal behavior is part of current clinical management of the patient) ❑ High concern (preventing suicidal behavior is one of the main goals in the current management of the patient) ❑ Imminent concern (preventing suicidal behavior is the most important goal in the current clinical management of the patient)		

Suicide Safety Plan (SSP)

STANLEY & BROWN SAFETY PLAN	
Step 1: Warning signs that a crisis may be developing:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies – Specific things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name_____ Phone_____
2.	Name_____ Phone_____
3.	Place_____ 4. Place_____
Step 4: People whom I can ask for help during a crisis:	
1.	Name_____ Phone_____
2.	Name_____ Phone_____
3.	Name_____ Phone_____
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician/Agency Name_____ Phone_____
	Clinician Pager or Emergency Contact #_____
2.	Clinician/Agency Name _____ Phone_____
	Clinician Pager or Emergency Contact #_____
3.	Local Emergency Department_____
	Emergency Department Address_____
	Emergency Department Phone_____
4.	Suicide Prevention Lifeline Phone: **1-800-273-TALK (8255)**
Step 6: Making the environment safe (plan for lethal means safety):	
1.	_____
2.	_____
The one thing that is most important and worth living for is:	
	_____