Proposed Meeting Norms:

1. Chair calls on people to speak
2. Remember to include phone participants
3. No assumptions—except for best intentions.
4. Step up, step back. (Be aware of how much you are speaking. Create space for others.)
5. Correct gently, but do correct if something is offensive.
6. Lean into discomfort. (Be willing to experience some discomfort in service of learning from each other and honoring diverse perspectives.)
7. Take good care of yourself emotionally and physically during meetings.
8. Uphold commitments
9. Avoid Acronyms

lines for life | OREGON SUICIDE PREVENTION CONFERENCE

Strength in Community

Creating healthy connections

March 13 + 14, 2018

Camp Withycombe | Clackamas, Oregon

— Save the date —

For more information about this conference, contact **Asa Wright**, Lines for Life Prevention Projects Coordinator | 971.247.9072 or asaw@linesforlife.org

Oregon Health Authority

Oregon Alliance to Prevent Suicide
PROPOSED 2018- Based on Draft2017 Public Policy Priorities

Public Policy Development: Direction to the Alliance from the Youth Suicide Intervention and Prevention Plan

1. Oregon Health Authority (OHA), in collaboration with other partners, will develop a charter that defines the membership and purposes of an Oregon Alliance to Prevent Suicide (Alliance) by March 2016. (1.1.a.) OHA, in collaboration with other partners, will recruit identified executives and stakeholders for the Alliance. (1.1.b) The first meeting of the Alliance will take place. (1.1.c.) ***Completed on September 21, 2016.***
2. By June 2017, develop a plan to foster and sustain statewide policy development and leadership in suicide prevention. (1.1.d.).
3. **By December 2016**, the Alliance will promote adoption of Zero Suicide as an organizational goal for health systems and payers, and will review and provide recommendations on model policies, practices and outcome measures that support behavioral health and primary care integration among providers and health systems. (1.2.a.)
4. **By December 2016**, identify state and local policy priorities, needed fiscal investments, and information on the value and return on investments, and develop a plan to communicate the agenda to state and local policy makers. (2.2.a.)
5. By March 2018, oversee a strategic plan for developing, implementing and evaluating means safety counseling and other programs that are research-informed, culturally relevant and respectful of community values. (5.1.a.)
6. By March 2019, OHA and Alliance collaborate to create a legislative agenda that includes provision of suicide risk assessment and crisis counseling, at the in-network level of benefits… (7.3.c.)
7. By March 2019, OHA and Alliance collaborate to recommend protocols and implementation strategies for conducting check-ins within 48 hours of release from the emergency department of patients aged 10-24 years at risk of suicide. (7.4.b.)
8. By March 2019, Alliance will collaborate with stakeholders to explore strategies for emergency departments to adopt best practices for planning at release, including specific types of protocols. (7.4.c.)

Public Policy Concepts for 2017 by Committee/Workgroup

1. **Zero Suicide (1.2.a.):**
    - Consider passage of legislation modeled after Colorado bill 147 to adopt the aspirational goal of Zero Suicide in Oregon. Source: http://www.leg.state.co.us/clics/clics2016a/csl.nsf/fsbillcont/E8B9508CBF48384B87257F2400659D52?Open&file=147_enr.pdf
    - Make a presentation to the Quality Health Outcomes Committee and Health Evidence Review Commission on value of implementing Zero Suicide.

2. **Workforce Development**:

- Assess university curricula for behavioral and medical professionals and CEU requirements for suicide prevention, risk assessment, intervention and treatment of suicidal individuals.
- Require ASIST or other training requirements for peer and family support specialists.
- Add CEU requirements for middle school and high school teachers.
- Assess curricula of professional associations such as OMA/OCCAP/OPPA and psychology, nursing, social work associations.
- Research and recommend guidelines and policies for use of family and peer supports.

3. **Evaluation/Data**:
    - Develop measures for all committee actions to determine progress on implementing the Plan and report to OHA on progress by September 2017. Evaluation Team is Working On This
    - Monitor OHA Health Systems and Public Health Divisions collection and tracking of suicide data.

4. **Continuity of Care and Risk Response**:
    - Conduct an assessment to determine what suicide risk assessments, safety planning and lethal means counseling models are being used in medical settings, including primary care and emergency departments, and behavioral health settings, *and school settings* consistent with Joint Commission Sentinel Alert 56. (6.2.b, 6.2.c, 7.3.b, 8.2.b.) Source: https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf
    - Expand the table of permissible treatment codes that cover screening for suicide, transition planning, follow up to hospitalization, and for consultation between physicians to promote coordinated care after a suicide behavior. By being able to bill for these services we are more likely to see the services done.
    - Develop a plan to integrate high school and university health centers into hospital and community resources for mental health treatment and suicide prevention.
    - Identify ways for stakeholders to overcome 'siloing' and promote information sharing.
    - Identify and promote funding for best practice community programs (out-patient) following release from residential treatment.
    - Review and revise Oregon Health Plan policies on crisis response and intervention for best practices for suicide risk assessments, safety planning and lethal means counseling. Sources:
    - ✓ Risk assessment: http://www.cssrs.columbia.edu/
    - ✓ Lethal means counseling: http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0
    - ✓ Safety Planning
        - http://www.sprc.org/sites/default/files/resource-program/Brown_StanleySafetyPlanTemplate.pdf
        - http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means-0

- Expand use of the Connect Program for postvention in pilot sites and expand statewide as indicated. Source: http://www.theconnectprogram.org/training/reduce-suicide-risk-and-promote-healing-suicide-postvention-training Year Two of Pilot Begins 2018 Jackson, Lane and Deschutes
- Recommend a program or system and funding source to allow for expedited contracting by OHA for rapid postvention services to communities.

5. **Outreach and Awareness**:
    - Hold an annual Suicide Prevention Summit to feature implementing the Zero Suicide initiative, national and state speakers in best practice programs, and feature innovations in suicide prevention and intervention in communities in Oregon. Scheduled March 2018
    - Working with and through relevant NGOs, Businesses, community groups, schools, etc., and utilizing evidence-based programs and tools, offer suicide awareness to the general public.
- Identify resources for and by youth on safe online practices for youth, conduct a social marketing campaign for youth, develop a suicide prevention application for cell phones, and hold a Youth Summit for leadership development in suicide prevention and early intervention (2.3.a).

6. **Groups at disproportionate risk of suicide**:
    - Review all committee actions through the lens of groups at disproportionate risk of suicide and provide feedback to incorporate these perspectives.
        - ✓ Make recommendations on ally trainings and consult with schools on developing, adopting and implementing protocols to address risk and protective factors in school settings. (Plan page 34)
        - ✓ Make recommendations on providing suicide prevention resources to Oregon Tribes in implementing culturally appropriate suicide prevention and intervention programs. (Plan page 33)
        - ✓ Make recommendations on identifying and developing online and other easily accessible tools to support and educate suicide attempt survivors (people who have attempted suicide or experienced serious ideation) and loss survivor (people who have lost someone to suicide) support group leaders on best practices in facilitating support groups. (Plan page 33)
        - ✓ Make recommendations on issues relating to military members, veterans, and their families. (Plan page 35-36)

Summary of Bills Related to Suicide—Prepared for Oregon Alliance to Prevent Suicide
Quarterly Meeting January 18, 2018
Possible Areas of Action Highlighted

2015-2017 Mental Health Bills (associated with Keny-Guyer MH Workgroup)

In 2015, the following bills passed into law.

HB2023 - requires hospitals to adopt and enforce policies for discharging patients who are hospitalized for mental health treatment, meaning patients admitted to a psychiatric inpatient hospital for treatment, and make the policies developed by each hospital publicly available.
Rules for this bill are in OAR 333-505-0055. These are hospital services and licensing rules.

HB3378 - describes requirements for hospitals discharging *any patient* from an inpatient hospitalization to a setting where a "lay caregiver" (the patient's family or other chosen representative) will be providing support.
Rules for this bill are in OAR 333-505-0055. These are hospital services and licensing rules.

HB 2948 - clarifies the conditions under which protected health information may be disclosed by a healthcare provider without obtaining an authorization from the individual or a personal representative. It specifies information that may be disclosed by healthcare provider for an individual being treated for mental illness. It specifies that healthcare provider making disclosure is not subject to any civil liability. It places this clarification in Oregon Statute.
Rules for this bill are in OAR 333-505-0055. These are hospital services and licensing rules.

In 2017, the following bills were passed into law:

HB 3091 - Although existing law requires health carriers to cover services in emergency settings and to adhere to mental health parity requirements, certain patients were not receiving behavioral health assessments as part of care during a behavioral health crisis and were not adequately transitioning from an acute care setting to community-based care. House Bill 3091 provides clarity regarding the services to be provided during these events and requires the Department of Consumer and Business Services to adopt rules defining coordinated care and case management to ensure patients with coverage through coordinated care organizations or the commercial health insurance market are properly assessed and receive the support necessary for transition to community-based care.
A RAC met twice this fall; ***Proposed rules OAR 836-053-1403 were filed*** *on 11/27/2017.*

Note public comment period was open until 1/2/2019. Visit http://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx and click on section about Defining Coordinated Care and Case Management to see proposed rules and all comments submitted currently. **Samples of comment letters include those submitted by Alliance Members Jerry Gabay, Julie Magers, Representative Keny-Guyer**

HB 3090 - states that hospitals shall adopt, maintain and follow written policies that pertain to the release of a patient from the emergency department who was seen for a behavioral health crisis.
Proposed rules OAR 333-505-0055 and 333-520-0070; RAC is currently in process, held two meetings in Nov/Dec and another scheduled for 1/5/2018. Proposed rules under discussion are attached.

[POSSIBLE ACTION] any Alliance Members who would like to make comments, be informed of proposed rule filings, or other action can contact Mellony Bernal MELLONY.C.BERNAL@dhsoha.state.or.us to get on the mailing list. This rule is of particular importance to topic of suicide prevention/intervention, as it pertains to people being released from EDs when being seen for behavioral health crisis, including suicidal thoughts, actions, risk. A number of Alliance Members are integrally involved in this process and can help guide people new to the process who would like to submit comments.

Summary of Bills Related to Suicide—Prepared for Oregon Alliance to Prevent Suicide
Quarterly Meeting January 18, 2018
Possible Areas of Action Highlighted

Alliance to Prevent Suicide Bylaws (Draft 9/15/17)

Purpose and Background of the Alliance

Suicide is among the leading causes of death in Oregon, and is a major public health issue nationally. There are more than 650 suicide deaths in Oregon each year, more than 2,100 hospitalizations due to suicide attempts and is the second most common cause of death for youth age 10 to 24 in Oregon

In 2014, the Oregon State Legislature mandated development of a 5-year plan to address Oregon's high rate of suicide among individuals age 10 through 24-years-old.4. The Oregon Youth Suicide Intervention and Prevention Plan was signed by the Oregon Health Authority and submitted to the Legislature in January 2016. The plan calls for the creation of the Oregon Alliance to Prevent Suicide to develop a public policy agenda for suicide intervention and prevention across agencies, systems and communities. The Alliance is charged with overseeing implementation of the plan and evaluating outcomes related to suicide prevention in Oregon.

Scope of Plan

Alliance responsibilities in the Youth Suicide Intervention and Prevention Plan include:

1.1.a. OHA, in collaboration with other partners, will develop a charter that defines the membership and purposes of an Oregon Alliance to Prevent Suicide (Alliance).

- *The Alliance will oversee integration and coordination of suicide prevention activities statewide.*
- *Members will include, but not be limited to, executives in private business and government, clergy, behavioral health and primary care providers, advocates, youth/young adults and families, attempt and loss survivors, and diverse cultural groups.*

1.1.d. By June 2017, the Alliance will develop a plan to foster and sustain statewide policy development and leadership in suicide prevention.

1.2.a. Based on recommendations from the Zero Suicide Work Group, the Alliance will promote adoption of Zero Suicide as an organizational goal for health systems and payers, and will review Work Group priorities and recommendations on model policies, practices, and outcome measures that support behavioral health and primary care integration among providers and health systems.

2.2.a. By July 2016, the Alliance will develop a policy agenda for suicide prevention that identifies state and local policy priorities, needed fiscal investments, and information on

the value and return on investments, and develop a plan to communicate the agenda to state and local policymakers.

7.3.c. By March 2019, OHA will collaborate with the Alliance to create a legislative agenda that includes provision of suicide risk assessment and crisis counseling, at the in-network level of benefits, delivered by community mental health programs or other providers. Provision of suicide risk assessment and crisis counseling should be considered an essential health benefit that cannot be denied due to provider panel restrictions, pre-authorization requirements or other administrative functions.

7.4.b. By March 2019, OHA and the Alliance will collaborate with youth and young adults, families, public and private insurers, emergency department, behavioral health providers and other subject matter experts to recommend protocols and implementation strategies for conducting check-ins within 48 hours of release from the emergency department of patients aged 10-24 years at risk of suicide…

7.4.c. By March 2019, the Alliance and stakeholders will explore options and recommend strategies for emergency departments to adopt best practices for planning at release for patients aged 24 years and younger in mental health or suicide crisis.

Duties

Alliance members must:

- Be familiar with the Oregon Youth Suicide Intervention and Prevention Plan and the responsibilities it designates for the Alliance
- Learn about and share best practices in suicide, suicide prevention, intervention,treatment and postvention.
- Communicate the needs and concerns of their constituencies to the Alliance.
- Communicate issues under consideration by the Alliance to their constituencies to obtain feedback.
- Communicate suicide prevention policy initiatives with Children's System Advisory Committee and align efforts when possible.
- Maintain a statewide perspective for what will work in Oregon.
- Serve on committees or work groups as appropriate to their areas of interest.
- Support Alliance public policy agenda and other initiatives, and advocate for them as appropriate.
- Attend quarterly meetings, preferably in person.
- Attend the annual Oregon Suicide Prevention Conference, if possible.
- Participate in timely decision-making through voting by email, in-person, or by phone.

- Participate in decision-making with timely responses and by voting in person, by email or by phone.

The Suicide Prevention Alliance Liaison will support the Alliance membership and the implementation of the Youth Suicide Intervention and Prevention Plan by:

- Providing meeting logistics, materials, facilitation and minutes for quarterly Alliance meetings and supporting Alliance committee work.
- Coordinating with Local Mental Health Authorities/Community Mental Health Programs and community stakeholder groups by conducting research and promoting and managing prevention, intervention and postvention programs and trainings.
- Developing and updating a Strategic Action Plan, including collaboration with researchers and program evaluators to assess suicide prevention, intervention and postvention outcomes, coordinating and monitoring activities of the Alliance, managing and reporting progress, and developing/monitoring communication and marketing strategies.
- Other duties as needed.

Alliance Meetings

Meetings of the full Alliance will be held quarterly. Special meetings via conference calls will be scheduled as needed. A designee may be delegated by an Alliance member to represent the member by attending and voting at a quarterly meeting. Members will notify the liaison or the Association of Community Mental Health Programs in advance if they are sending a designee or will miss a meeting.

Voting

For issues of lower importance or those of a time-sensitive nature, a majority of respondents will determine the decision. If a motion is made at an Alliance meeting, all members present, as well as those who are in attendance via phone, will participate in the vote. Alternatively, a vote may be conducted via email. The Alliance executive committee will develop a clear protocol for email voting and distribute it to all members.

For high-priority decisions, if members do not respond within the timeframe requested by the Suicide Prevention Liaison or Chair, a final determination will be carried by a majority of those responding.. The Executive Committee is authorized to vote on policy recommendations between quarterly meetings on behalf of the full Alliance as needed. Responses may be collected via email polling. Classification of such decisions as low- or high-priority will be made by the Executive Committee of the Alliance.

Committees

There are six committees within the Alliance:

- Executive
- Workforce Development
- Continuity of Care
- Outreach and Awareness
- Schools,
- Evaluation & Data.

Each committee will meet at least quarterly. These meetings will be primarily to establish goals and set deliverable tasks for the committee members and for the Suicide Prevention Alliance Liaison to accomplish between meetings. Each committee will have a committee chair tasked with facilitating the committee meetings and assisting the Liaison in ensuring goals are met and deliverables are completed. Committee chairs will also assist the Liaison in scheduling and setting meetings. Chairs will also report to the Executive Committee regarding proposals and decisions summarized from their committees, and work with the Executive Committee to review and revise these proposals. In addition to the committees, time limited workgroups may be formed to achieve specific tasks.

Executive Committee

1. The Executive Committee shall consist of:
    - Alliance Chair,
    - Chairs of each committee,
    - Non-voting Suicide Prevention Alliance Liaison,
    - OHA/HSD Representative,
    - Healthcare Provider,
    - Suicide attempt survivor,
    - Bereavement survivor (family member of a person who attempted or died by suicide), and
    - A youth representative.
2. The Alliance Chair will lead meetings, and in their absence the Vice Chair may take the lead. The Chair and Vice-Chair terms will be for a period of two years. The first chair's appointment will be for one year to allow for staggered terms.
3. The Executive Committee will meet prior to each of the full Alliance quarterly meetings, and additional meetings will be held as needed.
4. The Executive Committee shall:
    - meet to develop and review full Alliance quarterly meeting agendas;

- review and approve recommendations or proposals from each of the committees;
- recommend to the Alliance new or updated policies and procedures;
- review and make recommendations on other items to come before the Alliance;
- make decisions between meetings on behalf of the Alliance membership;
- make recommendations to OHA on new Alliance members;
  prioritize special projects, including focus on equity and inclusion, specifically certain cultural groups with a disproportionate risk for suicide (including LGBTQ youth, military members, veterans and their families, Native Americans, bereavement and attempt survivors, etc.), and designating Alliance members and recruiting other stakeholders to work on a time-specific project as an ad hoc workgroup.

Recognize, Connect!
Helping Individuals at Risk of Suicide
A Connect Suicide Prevention Training

A collaboration between NAMI NH and
BestCare Prevention Services

~Kimberlee R. Jones, Supervisor,
Prevention Services
850 SW 4th Street, Suite 104 · Madras, OR 97741
541.475.4884
BestCarePrevention.com | BestCareTreatment.org

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Connect Version 3/1/2017

Readiness in Central Oregon

- Perception among community members that it's the schools' or local behavioral health's responsibility to prevent suicide
- Survivors don't talk; don't connect
- Some system silos
- Low capacity
- Culturally diverse community
- Subpopulation's perception that it's "their" problem
- Serious attempt:
  - 6.8% of 6th grade students
  - 18,7 and 29% of 6th and 8th grade students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities

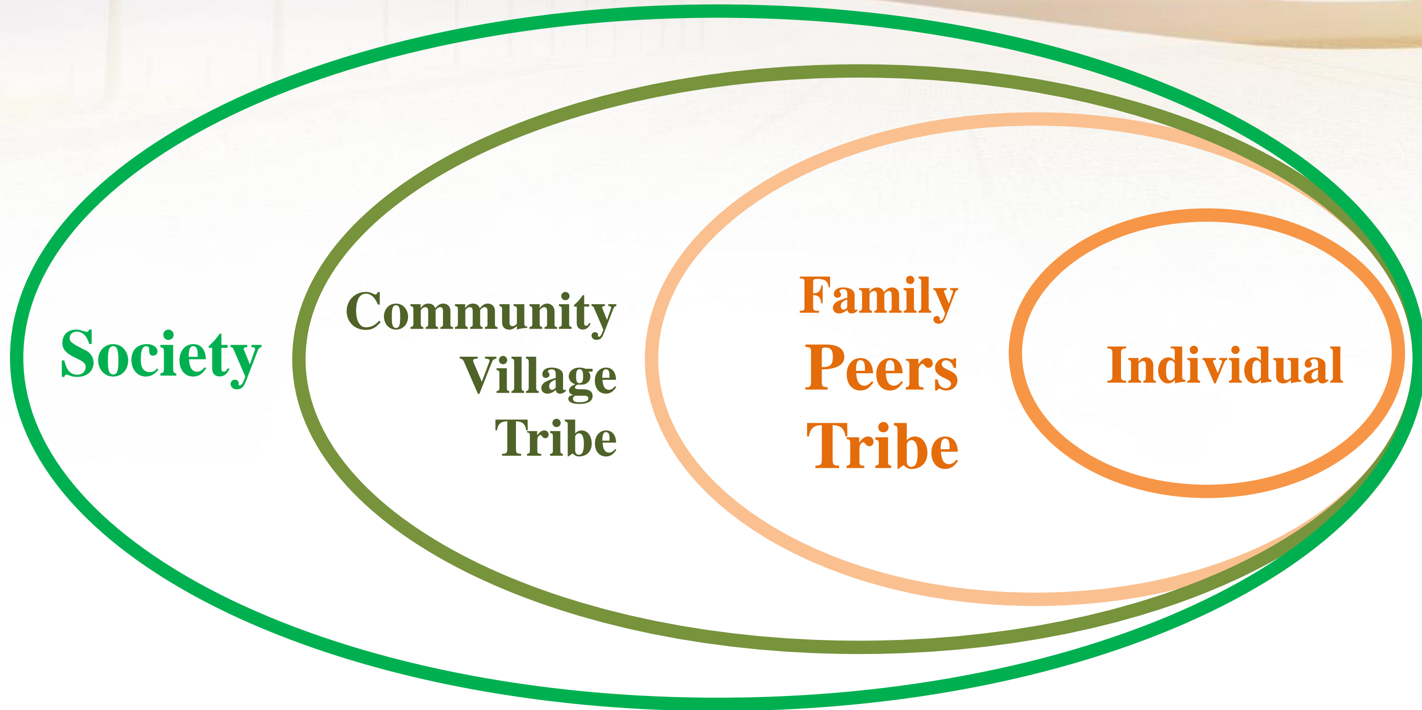
Jefferson County Training Plan

- Connect Gatekeeper Suicide Prevention Training
  - Prioritize groups, providers, faith community, and businesses in contact with higher risk populations; include training for parents and community members.
- Connect Youth Leader Training – Introduce once adults have been trained
- Connect Suicide <u>Postvention</u> Training
- Mental Health First Aid
- A sprinkling of QPR for those who cannot participate in comprehensive trainings

Connect Basic Tenets

- **Regardless of one's role in the community, we are gatekeepers at all times.**
- Gatekeepers can be from many walks of life, and whether experienced or not, have a role in preventing suicide.
- Gatekeeper training is the basis by which all participants begin with same information and use the same language.
- Starting together as gatekeepers reinforces the working relationships that will be critical to reinforcing the safety net of suicide prevention.

Connect Gatekeeper Training



- Suicide is a public health problem.
- Suicide is generally preventable.
- **Everyone plays a part in preventing suicide**.
- Suicide prevention is a **priority** for Jefferson County.
- Suicide prevention goes across the **entire lifespan**.
- Suicide prevention covers a wide range of high-risk behaviors, not just suicide.
- **Cultural factors** are important in preventing suicide.
- Greater awareness and communication between individuals and systems help reduce suicide risk in a community.
- Recognize, Connect! are two key actions in preventing suicide.

Connect Gatekeeper Training

- Connect’s curriculum includes how to identify suicide warning signs and intervene with a person at risk.
- Training facilitates developing a suicide prevention plan in the context of the community's resources and culture.
- Prior to the training, Connect trainers identify local systemic, cultural, or other issues.
- Connect focuses on the community as a whole and how to work across systems to build a safety net for people at risk.

Connect Gatekeeper Training *(Continued)...*

Curriculum has been developed for:

Educators	Community members
Faith leaders	Hospital emergency departments
Law enforcement	Mental health providers
Military	Primary care providers
Substance abuse providers	Social Services
Medical Examiners	Funeral Directors
Universities	Older Adult Service Providers

Connect Gatekeeper Training *(Continued)...*

Training Highlights:

- How to recognize early warning signs of mental illness, substance abuse and other risk factors leading to suicide
- How to intervene and connect a person who may be at risk for suicide to resources
- **Attitudes** toward suicide and the effects of **stigma**
- National, state, and local suicide **trends** and statistics
- Individual and **community risk** and **protective factors**
- Best practices on **restricting access** to lethal means and safe messaging
- The **influence** of electronic communication and **media**
- Roles and responsibilities of local service providers and others in the community to collaborate in building a safety net for persons at risk

Connect Postvention Training

Because we know that suicide loss is one of the highest risk factors for suicide, **postvention aligns with best practices on how to coordinate a comprehensive and safe response to a suicide loss.** *Connect* has developed postvention protocols for:

Educators	Emergency medical services
Faith leaders	Funeral directors
Law enforcement	Mental health providers
Military	Medical examiners
Coroners	Military
Social Service Providers	

Connect Postvention Training *(Continued)…*

Training Highlights

- Strategies for reducing the risk of contagion
- Review of the complexity of suicide-related grief, especially for different age groups
- Recommendations for funerals and memorial activities
- Suggestions of how to talk to survivors of suicide loss to promote their healing
- Best practices for safe messaging about suicide and responding to the media
- Identification of community resources to promote healing

Youth Leader

- Youth Leader training emphasizes that the role of youth participants and trainers is to seek help from a trusted adult whenever there is a concern, NOT to take on the role of a counselor.
- Youth Leader training is designed for youth in the 9th grade and older.

Youth Leader Training Highlights

- Youth Leader training is a part of a *comprehensive* suicide prevention effort.
- National Best Practices for identifying and responding to other at risk youth
- The important role youth play in preventing suicide
- Skills and confidence to recognize warning signs for suicide
- Why it is important to involve a *trusted adult* immediately when concerned about someone at risk
- During the training, youth Connect with trusted adults who participate in and supervise the training.
- Returning to Jefferson in May 2018 — Youth leaders facilitate the 2018 T4T for additional Youth Leaders!

Youth Leader Training Highlights *(Continued)…*

- Resources and *increased comfort* to connect an at risk person with help
- Suicide statistics and the influence of gender, culture, electronic communication and social networking on suicide risk and prevention
- Individual, family, school and community risk and protective factors and ways to strengthen the positive influences that prevent suicide and other risky behaviors
- Self-care skills

Jefferson County's Trained Gatekeepers!

Veterans and VSOs – December 2017

Gatekeeper Training – May 2017

~Kimberlee Jones, Supervisor, *Prevention Services*
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BestCarePrevention.com | BestCareTreatment.org

Implementation Science and the YSIPP

ALLIANCE EVALUATION & DATA TEAM

Dissemination vs. Implementation Research

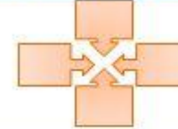
- The purpose of **dissemination research** is to understand how best to spread & sustain knowledge.

- **Implementation research** improves individual outcomes & population health through strategic use of evidence-based practices and programs.

Active Implementation Frameworks

- **EFFECTIVE & USABLE INTERVENTIONS**
  - *What exactly are people saying and doing that makes things better for children, adults, and families?*
- **STAGES**
  - *What steps lead to successful implementation?*
- **DRIVERS**
  - *What critical supports are needed to make this change? What is the infrastructure?*
- **TEAMS**
  - *Who takes responsibility for and helps guide the change process?*
- **IMPROVEMENT CYCLES**
  - *How can we create more hospitable environments, efficiently solve problems and get better?*

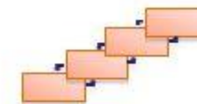
Effective & Usable Interventions



Stages

Drivers

Teams



Cycles

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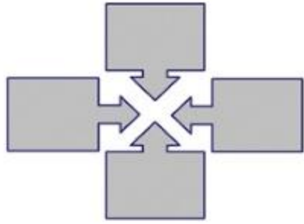
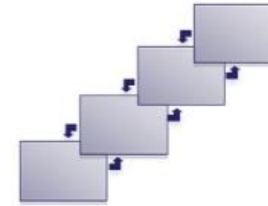
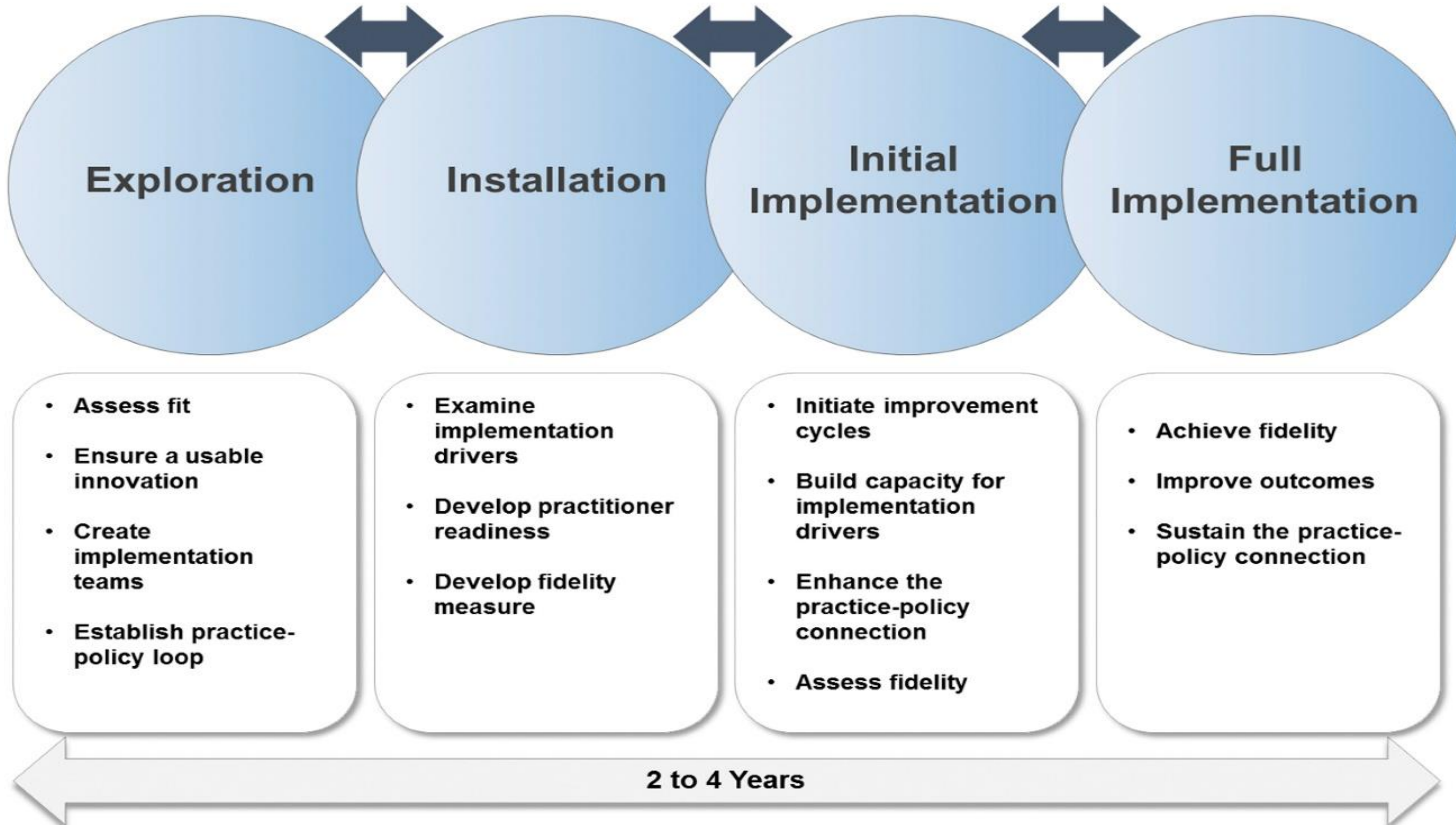
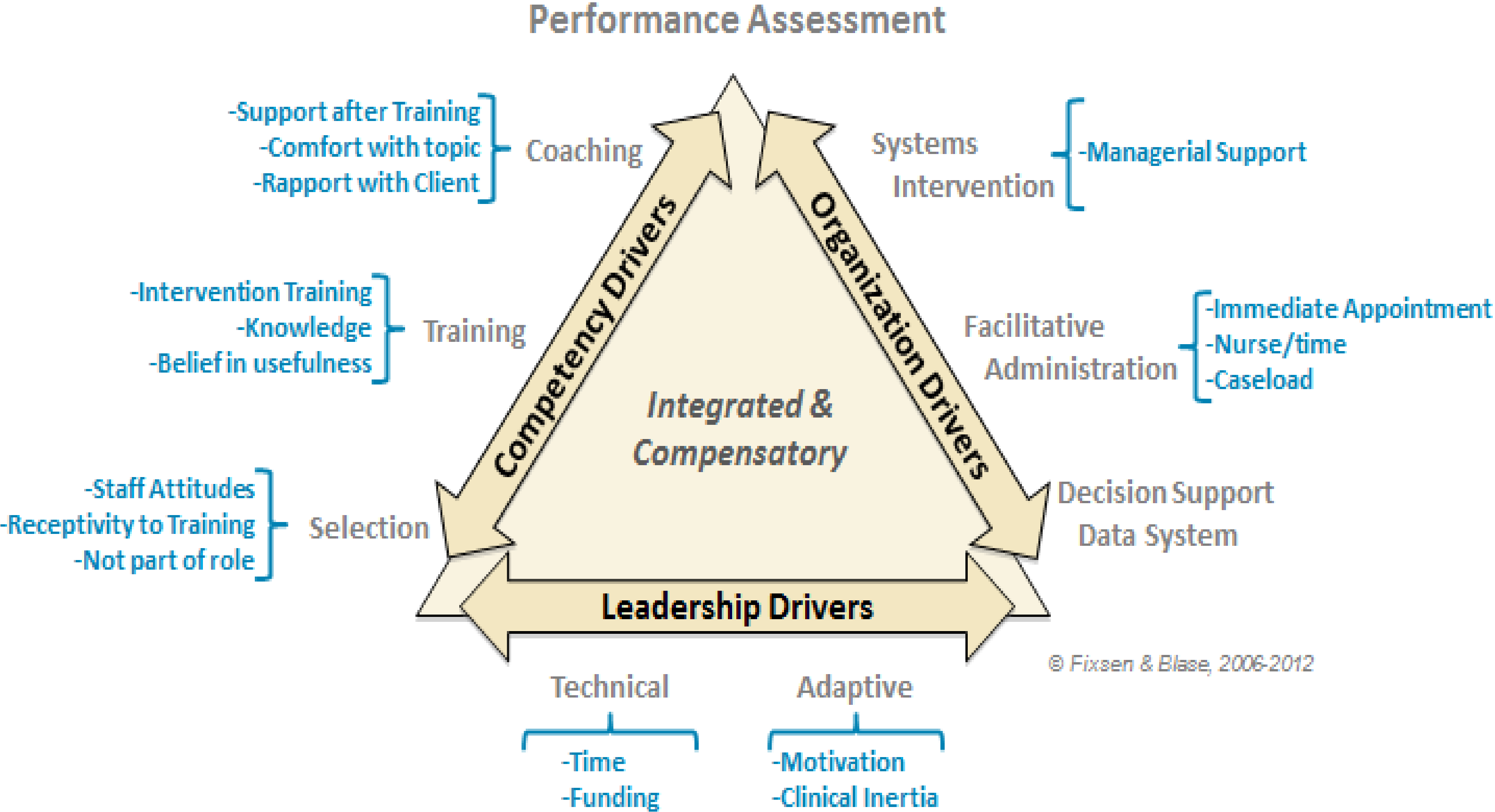
Active Implementation Frameworks

Usable Innovations	Stages	Drivers	Cycles	Teams
				
Innovations need to be fully operationalized through identification and description of a shared philosophy, essential functions, operational definitions, and a fidelity assessment	Implementation strategies need to be stage-appropriate; stages include exploration, installation, initial implementation, and full implementation	Clearly defined infrastructure components are necessary to support the innovation; includes organizational supports, competency supports for practitioners, and leadership capacity	Data-driven processes, such as PDSA cycles, should be used to inform decision making around innovation improvement and institutionalization of policy-practice feedback loops	Accountable structures are needed in the form of implementation teams to move innovations through the stages of implementation

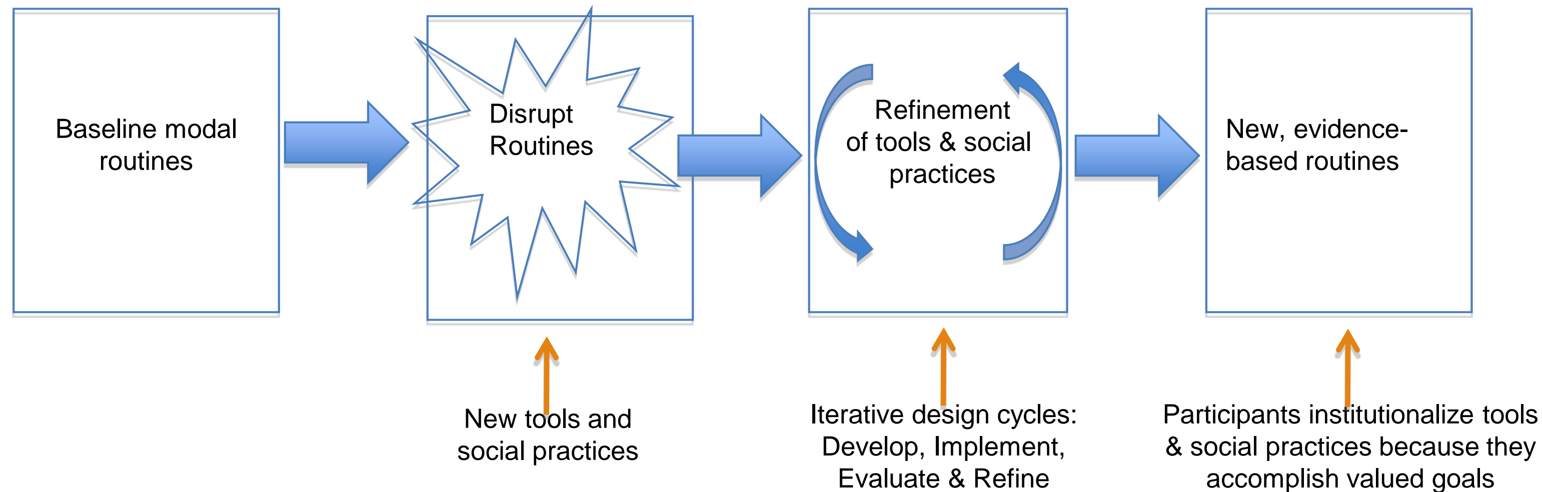
Stages of Implementation



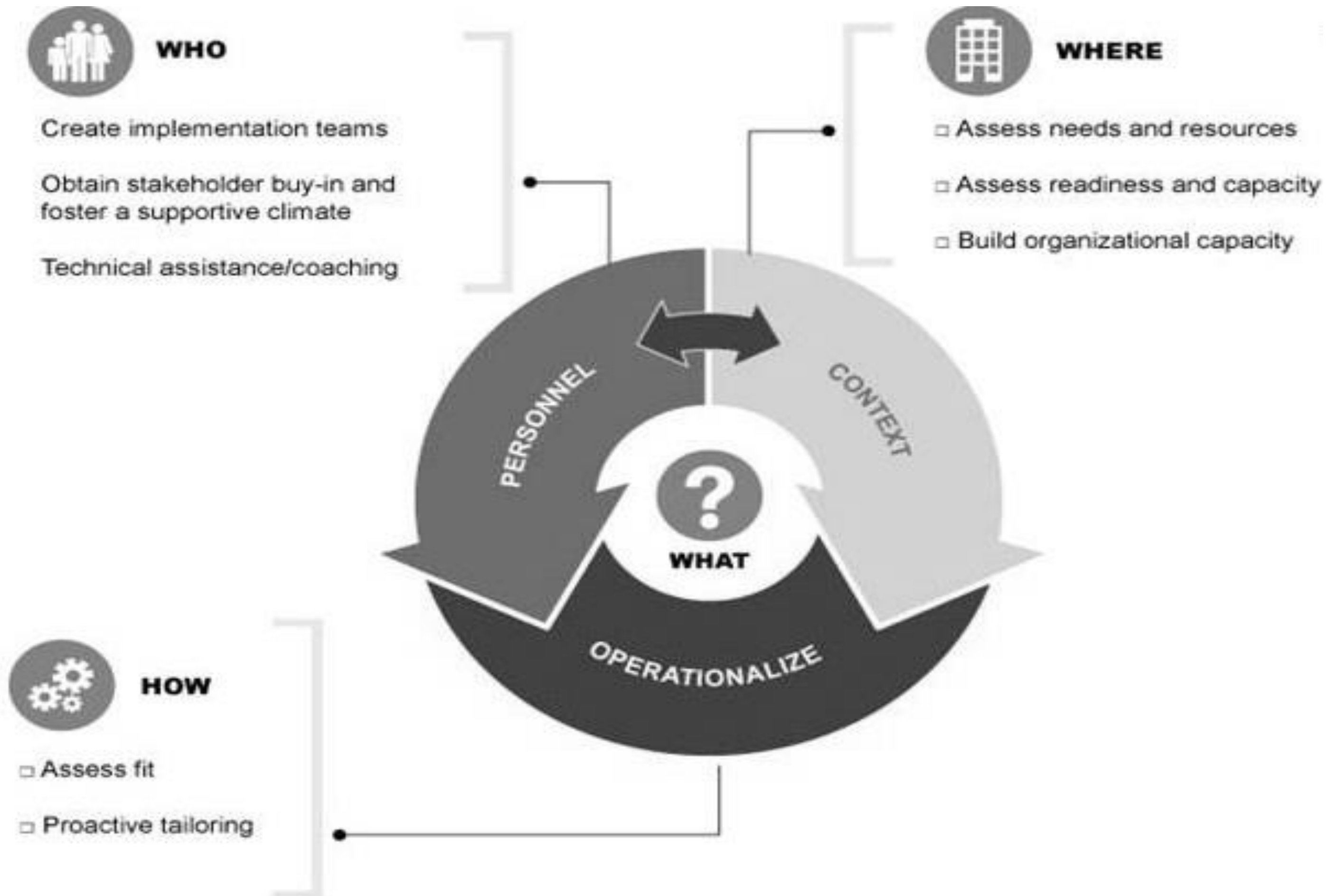
Implementation Drivers



Organizational Change Process



Planning for Implementation



Implementation Outcomes

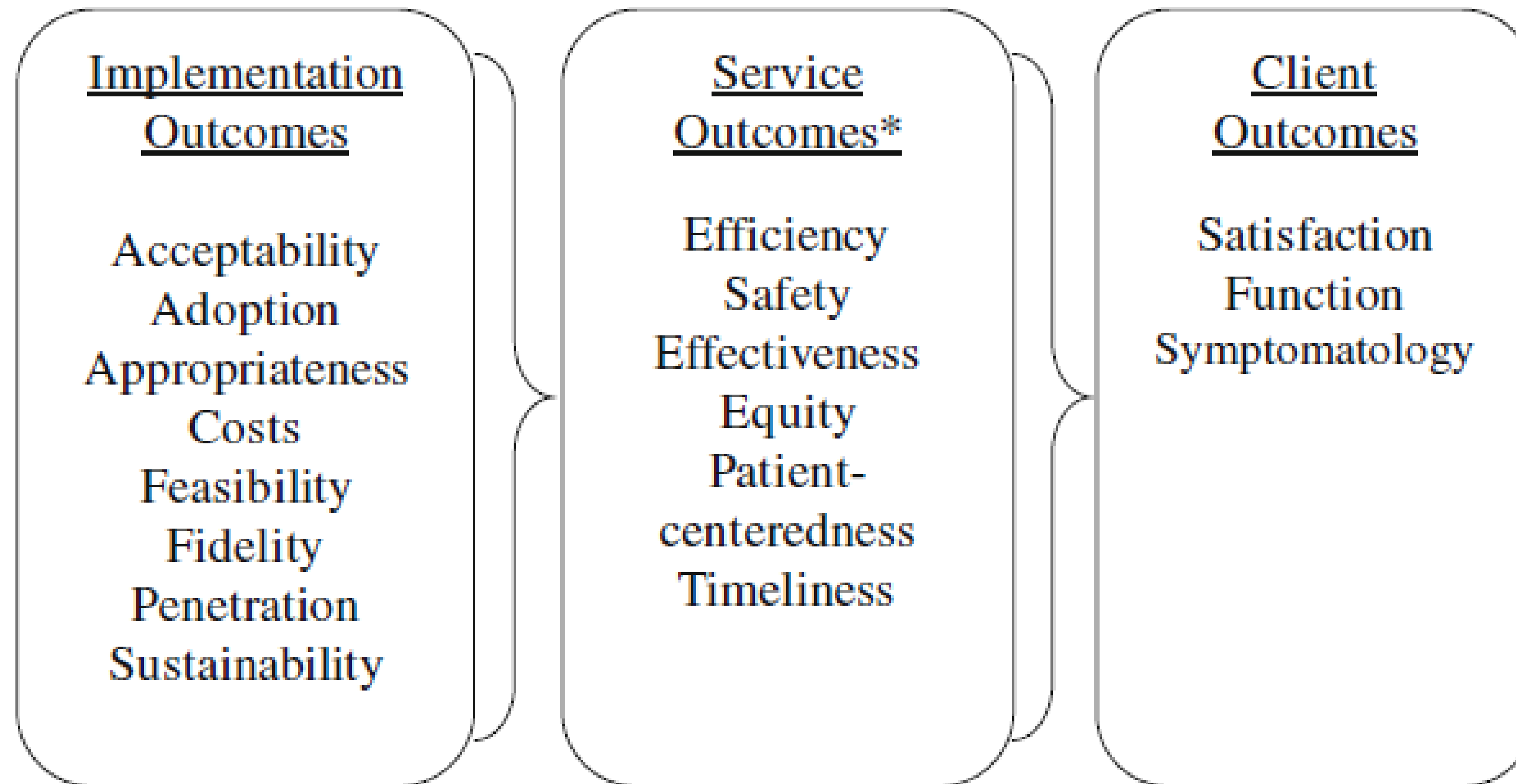


Fig. 1 Types of outcomes in implementation research

Passive vs. Active Implementation Strategies

- **Passive implementation strategies**
  - Posting information on a website
  - Disseminating toolkits without training & support
- **Active implementation strategies**
  - Train & educate stakeholders (e.g., Connect)
  - Use of evaluative & iterative strategies
  - Provide interactive assistance (e.g., Learning Collaborative)
  - Develop stakeholder interrelationships
  - Adapt & tailor to the context

A Key Formula for Success (Fixsen et al., 2013)

Effective Innovation

x

Effective Implementation

x

Enabling Contexts

=

Significant Outcomes

Discussion Questions

- As members of the Alliance, how can we be more proactively engaged in meeting the YSIPP objectives?

- What supports are needed to more actively engage in the mission of the Alliance given the constraints of the members (volunteers)?

- How can we improve collaborative communication to support implementation of the YSIPP objectives?

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OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 500
HOSPITALS, GENERALLY:
DEFINITIONS, APPLICATION AND RENEWAL PROCEDURES, FEES, FACILITY CLOSURE

DRAFT

333-500-0010
Definitions

As used in OAR chapter 333, divisions 500 through 535, unless the context requires otherwise, the following definitions apply:

(1) "Assessment" means a complete nursing assessment, including:

(a) The systematic and ongoing collection of information to determine an individual's health status and need for intervention;

(b) A comparison with past information; and

(c) Judgment, evaluation, or a conclusion that occurs as a result of subsections (a) and (b) of this definition.

(2) "Authentication" means verification that an entry in the patient medical record is genuine.

(3) "Authority" means the Oregon Health Authority.

(4) "Certified Nursing Assistant" (CNA) means a person who is certified by the Oregon State Board of Nursing (OSBN) to assist licensed nursing personnel in the provision of nursing care.

(5) "Chiropractor" means a person licensed under ORS chapter 684 to practice chiropractic.

(6) "Conditions of Participation" mean the applicable federal regulations that hospitals are required to comply with in order to participate in the federal Medicare and Medicaid programs.

(7) "Deemed" means a health care facility that has been inspected by an approved accrediting organization and has been approved by the Centers for Medicare and Medicaid Services (CMS) as meeting CMS Conditions of Participation.

(8) "Discharge" means the release of a person who was an inpatient of a hospital including, but is not limited to~~and includes~~:

(a) The release and transfer of a newborn to another facility, but not a transfer between acute care departments of the same facility;

(b) The release of a person from an acute care section of a hospital for admission to a long-term care section of a facility;

(c) Release from a long-term care section of a facility for admission to an acute care section of a facility;

(d) A patient who has died; and

(e) An inpatient who leaves a hospital for purposes of utilizing non-hospital owned or operated diagnostic or treatment equipment, if the person does not return as an inpatient of the same health care facility within a 24-hour period.

(9) "Direct ownership" has the meaning given the term 'ownership interest' in 42 CFR 420.201.

(10) "Division" means the Public Health Division within the Authority.
(11) "Emergency Medical Services" means medical services that are usually and customarily available at the respective hospital in an emergency department and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or to provide care to a woman in labor where delivery is imminent if the hospital is so equipped and, if the hospital is not equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.
(12) "Emergency Psychiatric Services" means mental health services that are usually and customarily available in an emergency department at the respective hospital and that must be provided immediately to prevent harm to the patient or others including but not limited to triage and assessment; observation and supervision; crisis stabilization; crisis intervention; and crisis counseling.
(13) "Financial interest" means a five percent or greater direct or indirect ownership interest.
(14) "Full compliance survey" means a survey conducted by the Division following a complaint investigation to determine a hospital's compliance with the CMS Conditions of Participation.
(15) "Governing body" means the body or person legally responsible for the direction and control of the operation of the hospital.
(16) "Governmental unit" has the meaning given that term in ORS 442.015.
(17) "Health care facility" (HCF) has the meaning given the term in ORS 442.015.
(18) "Health Care Facility Licensing Laws" means ORS 441.005 through 441.990 and its implementing rules.
(19) "Hospital" has the meaning given that term in ORS 442.015.
(20) "Indirect ownership" has the meaning given the term 'indirect ownership interest' in 42 CFR 420.201.
(21) "Licensed" means that the person to whom the term is applied is currently licensed, certified or registered by the proper authority to follow his or her profession or vocation within the State of Oregon, and when applied to a hospital means that the facility is currently licensed by the Authority.
(22) "Licensed nurse" means a nurse licensed under ORS chapter 678 to practice registered or practical nursing.
(23) "Licensed Practical Nurse" means a nurse licensed under ORS chapter 678 to practice practical nursing.
(24) "Major alteration" means any structural change to the foundation, roof, floor, or exterior or load bearing walls of a building, or the extension of an existing building to increase its floor area. Major alteration also means the extensive alteration of an existing building such as to change its function and purpose, even if the alteration does not include any structural change to the building.
(25) "Manager" means a person who:
(a) Has authority to direct and control the work performance of nursing staff;
(b) Has authority to take corrective action regarding a violation of law or a rule or a violation of professional standards of practice, about which a nursing staff has complained; or
(c) Has been designated by a hospital to receive the notice described in ORS 441.174(2).

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(26) "Minor alteration" means cosmetic upgrades to the interior or exterior of an existing building, such as but not limited to wall finishes, floor coverings and casework.
(27) "Mobile Satellite" means a MRI, CAT Scan, Lithotripsy Unit, Cath Lab, or other such modular outpatient treatment or diagnostic unit that is capable of being moved, is housed in a vehicle with a vehicle identification number (VIN), and does not remain on a hospital campus for more than 180 days in any calendar year.
(28) "NFPA" means National Fire Protection Association.
(29) "Nurse Midwife/Nurse Practitioner" means a registered nurse certified by the OSBN as a nurse midwife/nurse practitioner.
(30) "Nurse Practitioner" has the meaning given that term in ORS 678.010.
(31) "Nursing staff" means a registered nurse, a licensed practical nurse, or other assistive nursing personnel.
(32) "OB Unit" means a dedicated obstetrical unit that meets the requirements of OAR 333-535-0120.
(33) "On-call" means a scheduled state of availability to return to duty, work-ready, within a specified period of time.
(34) "Oregon Sanitary Code" means the Food Sanitation Rules in OAR 333-150-0000.
(35) "Patient audit" means review of the medical record or physical inspection or interview of a patient.
(36) "Person" has the meaning given that term in ORS 442.015.
(37) "Physician" means a person licensed as a doctor of medicine or osteopathy under ORS chapter 677.
(38) "Physician Assistant" has the meaning given that term in ORS 677.495.
(39) "Plan of correction" means a document executed by a hospital in response to a statement of deficiency issued by the Division that describes with specificity how and when deficiencies of health care licensing laws or conditions of participation shall be corrected.
(40) "Podiatrist" has the same meaning as "podiatric physician and surgeon" in ORS 677.010.
(41) "Podiatry" means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot, except treatment involving the use of a general or spinal anesthetic unless the treatment is performed in a licensed hospital or in a licensed ambulatory surgical center and is under the supervision of or in collaboration with a physician. "Podiatry" does not include the administration of general or spinal anesthetics or the amputation of the foot.
(42) "Public body" has the meaning given that term in ORS 30.260.
(43) "Registered Nurse" means a person licensed under ORS chapter 678 to practice registered nursing.
(44) "Respite care" means care provided in a temporary, supervised living arrangement for individuals who need a protected environment, but who do not require acute nursing care or acute medical supervision.
(45) "Retaliatory action" means the discharge, suspension, demotion, harassment, denial of employment or promotion, or layoff of a nursing staff person directly employed by the hospital, or other adverse action taken against a nursing staff person directly employed by the hospital in the terms or conditions of employment of the nursing staff person, as a result of filing a complaint.

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(46) "Satellite" means a building or part of a building owned or leased by a hospital, and operated by a hospital in a geographically separate location from the hospital, with a separate physical address from the hospital but that is within 35 miles from the hospital, through which the hospital provides:
(a) Outpatient diagnostic, therapeutic, or rehabilitative services;
(b) Psychiatric services in accordance with OAR 333-525-0000 including:
(A) Inpatient psychiatric services; and
(B) Emergency psychiatric services through an emergency department in accordance with OAR 333-520-0070; or
(c) Emergency medical services in accordance with OAR 333-500-0027.
(47) "Special Inpatient Care Facility" means a facility with inpatient beds and any other facility designed and utilized for special health care purposes that may include but is not limited to a rehabilitation center, a facility for the treatment of alcoholism or drug abuse, a freestanding hospice facility, or an inpatient facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the Division, after determination of the need for such classification and the level and kind of health care appropriate for such classification.
(48) "Stable newborn" means a newborn who is four or more hours post-delivery and who is free from abnormal vital signs, color, activity, muscle tone, neurological status, weight, and maternal-child interaction.
(49) "Stable postpartum patient" means a postpartum mother who is four hours or more postpartum and who is free from any abnormal fluctuations in vital signs, has vaginal flow within normal limits, and who can ambulate, be independent in self-care, and provide care to her newborn infant, if one is present.
(50) "Statement of deficiencies" means a document issued by the Division that describes a hospital's deficiencies in complying with health care facility licensing laws or conditions of participation.
(51) "Survey" means an inspection of a hospital to determine the extent to which a hospital is in compliance with health facility licensing laws and conditions of participation
Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.025

DIVISION 505
HOSPITAL ORGANIZATION AND MANAGEMENT

333-505-0030
Organization, Hospital Policies
~~(1) As used in this rule, "lay caregiver" means:~~
~~(a) In paragraph (4)(b)(A), an individual who, at the request of a patient, agrees to provide aftercare to the patient in the patient's residence.~~
~~(b) In paragraph (4)(b)(B), which applies to patients that are hospitalized for mental health treatment:~~
~~(A) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient;~~

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~~(B) For a patient who is 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.~~

(1~~2~~) A hospital's internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.

(2~~3~~) A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships.

(3~~4~~) A hospital shall adopt, maintain and follow written patient care policies that include but are not limited to:

(a) Admission and transfer policies that address:

(A) Types of clinical conditions not acceptable for admission;

(B) Constraints imposed by limitations of services, physical facilities or staff coverage;

(C) Emergency admissions;

(D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.610, 109.640, 109.670, and 109.675;

(E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; and

(F) A process for the internal transfer of patients from one level or type of care to another;~~.~~

(b) Discharge, ~~and~~ termination of services, and release from emergency department policies in accordance with OAR 333-505-0055 and OAR 333-520-0070;~~that address:~~

~~(A) For patients who identify a lay caregiver to provide aftercare, development of a discharge plan for continuity of patient care including but not limited to:~~

~~(i) Assessment of the patient's ability for self-care;~~

~~(ii) Opportunity for both the patient and lay caregiver to participate in discharge planning;~~

~~(iii) Instructions or training provided to the patient and lay caregiver, prior to discharge, for the lay caregiver to provide assistance with activities of daily living, medical or nursing tasks such as wound care, administering medications, or the operation of medical equipment, or other assistance relating to the patient's condition; and~~

~~(iv) Notification of the lay caregiver that patient is being discharged or transferred.~~

~~(B) On and after July 1, 2016 for patients hospitalized for mental health treatment, requirements that the hospital:~~

~~(i) Encourage the patient to sign an authorization form allowing for the disclosure of information that is necessary for a lay caregiver to participate in the patient's discharge planning and to provide appropriate support measures to the patient;~~

~~(ii) Assess the patient's risk of suicide with input from the patient's lay caregiver, if applicable;~~

~~(iii) Assess the long-term needs of the patient which include but are not limited to:~~

~~(I) Community-based services;~~

~~(II) Capacity for self-care; and~~

~~(III) Appropriate patient care where patient resided at time of admission;~~

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~~(iv) Develop a process to coordinate the patient's care and transition the patient to outpatient treatment that may include community-based providers, peer support, lay caregivers or other individuals who can implement the patient's care plan; and~~
~~(v) Schedule a follow-up appointment for no later than seven days after discharge. If a follow-up appointment cannot be scheduled within seven days, the hospital must document why.~~
(c) Patient rights;
(d) Housekeeping;
(e) All patient care services provided by the hospital;
(f) Maintenance of the hospital's physical plant, equipment used in patient care and patient environment;
(g) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403; and
(h) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273.
~~(5) Discharge policies developed in accordance with paragraph (4)(b)(A) of this rule must be publically available and:~~
~~(a) Must specify requirements for documenting who is designated by the patient as the lay caregiver and details of the discharge plan;~~
~~(b) May incorporate established evidence based practices;~~
~~(c) Must ensure that discharge planning is appropriate to the needs and acuity of the patient and the abilities of the lay caregiver;~~
~~(d) Must not delay a patient's discharge or transfer to another facility; and~~
~~(e) Must not require the disclosure of protected health information without obtaining a patient's consent as required by state and federal laws.~~
(4~~6~~) In addition to the policies described in section (3) of this rule, a hospital shall, in accordance with the Patient Self-Determination Act, 42 CFR 489.102, adopt policies and procedures that require (applicable to all capable individuals 18 years of age or older who are receiving health care in the hospital):
(a) Providing to each adult patient, including emancipated minors, not later than five days after an individual is admitted as an inpatient, but in any event before discharge, the following in written form, without recommendation:
(A) Information on the rights of the individual under Oregon law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;
(B) Information on the policies of the hospital with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;
(C) A copy of the directive form set forth in ORS 127.531, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and
(D) The name of a person who can provide additional information concerning the forms for directives.
(b) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive.
(c) Compliance with Oregon law relating to directives for health care.

(d) Educating the staff and the community on issues relating to directives.
(5~~7~~) A hospital's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.
(6~~8~~) Patient care policies shall be evaluated triennially and rewritten as needed, and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.
(7~~9~~) A hospital shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.
Stat. Auth.: ORS 441.025
Stats. Implemented: ORS ~~147.025,~~ 413.273, 441.025, 441.196 & 441.198

333-505-0050
Medical Records
(1) A medical record shall be maintained for every patient admitted for care in a hospital.
(2) A legible reproducible medical record shall include, but is not limited to (as applicable):
(a) Admitting identification data including date of admission.
(b) Chief complaint.
(c) Pertinent family and personal history.
(d) Medical history, physical examination report and provisional diagnosis as required by OAR 333-510-0010.
(e) Admission notes outlining information crucial to patient care.
(f) All patient admission, treatment, and discharge orders:~~.~~
(A) All patient orders shall be initiated, dated, timed and authenticated by a licensed health care practitioner in accordance with section (7) of this rule.
(B) Documentation of verbal orders shall include:
(i) The date and time the order was received;
(ii) The name and title of the health care practitioner who gave the order; and
(iii) Authentication by the authorized individual who accepted the order, including the individual's title.
(C) Verbal orders shall be dated, timed, and authenticated promptly by the ordering health care practitioner or another health care practitioner who is responsible for the care of the patient.
(D) For purposes of this rule, a verbal order includes but is not limited to an order given over the telephone.
(g) Clinical laboratory reports as well as reports on any special examinations. (The original report shall be recorded in the patient's medical record.)
(h) X-ray reports bearing the identification of the originator of the interpretation.
(i) Consultation reports when such services have been obtained.
(j) Records of assessment and intervention, including graphic charts and medication records and appropriate personnel notes.
(k) Discharge planning documentation in accordance with OAR 333-505-0055~~0030(5)(a)~~.
(l) Discharge summary including final diagnosis.
(m) Autopsy report if applicable.
(n) Such signed documents as may be required by law.

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(o) Informed consent forms that document:
(A) The name of the hospital where the procedure or treatment was undertaken;
(B) The specific procedure or treatment for which consent was given;
(C) The name of the health care practitioner performing the procedure or administering the treatment;
(D) That the procedure or treatment, including the anticipated benefits, material risks, and alternatives was explained to the patient or the patient's representative or why it would have been materially detrimental to the patient to do so, giving due consideration to the appropriate standards of practice of reasonable health care practitioners in the same or a similar community under the same or similar circumstances;
(E) The manner in which care will be provided in the event that complications occur that require health services beyond what the hospital has the capability to provide;
(F) The signature of the patient or the patient's legal representative; and
(G) The date and time the informed consent was signed by the patient or the patient's legal representative.
(p) Documentation of the disclosures required in ORS 441.098.
(3) A medical record of a surgical patient shall include, in addition to other record requirements, but is not limited to:
(a) Preoperative history, physical examination and diagnosis documented prior to operation.
(b) Anesthesia record including preanesthesia assessment and plan for anesthesia, records of anesthesia, analgesia and medications given in the course of the operation and postanesthetic condition.
(c) A record of operation dictated or written immediately following surgery and including a complete description of the operation procedures and findings, postoperative diagnostic impression, and a description of the tissues and appliances, if any, removed. When the dictated operative report is not placed in the medical record immediately after surgery, an operative progress note shall be entered in the medical record after surgery to provide pertinent information for any individual required to provide care to the patient.
(d) Postanesthesia recovery progress notes.
(e) Pathology report on tissues and appliances, if any, removed at the operation.
(4) An obstetrical record for a patient, in addition to the requirements for medical records, shall include but is not limited to:
(a) The prenatal care record containing at least a serologic test result for syphilis, Rh factor determination, and past obstetrical history and physical examination.
(b) The labor and delivery record, including reasons for induction and operative procedures, if any.
(c) Records of anesthesia, analgesia, and medications given in the course of delivery.
(5) A medical record of a newborn or stillborn infant, in addition to the requirement for medical records, shall include but is not limited to:
(a) Date and hour of birth; birth weight and length; period of gestation; sex; and condition of infant on delivery (Apgar rating is recommended).
(b) Mother's name and hospital number.
(c) Record of ophthalmic prophylaxis or refusal of same.

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(d) Physical examination at birth and at discharge.
(e) Progress and nurse's notes including temperature; weight and feeding data; number, consistency and color of stools; urinary output; condition of eyes and umbilical cord; condition and color of skin; and motor behavior.
(f) Type of identification placed on infant in delivery room;
(g) Newborn hearing screening tests in accordance with OAR 333-020-0130.
(6) A patient's emergency room, outpatient and clinic records, in addition to the requirements for medical records, shall be maintained and available to the other professional services of the hospital and shall include but are not limited to:
(a) Patient identification.
(b) Admitting diagnosis, chief complaint and brief history of the disease or injury.
(c) Physical findings.
(d) Laboratory and X-ray reports (if performed), as well as reports on any special examinations. The original report shall be authenticated and recorded in the patient's medical record.
(e) Diagnosis.
(f) Record of treatment, including medications.
(g) Disposition of case with instructions to the patient.
(h) Signature or authentication of attending physician.
(i) A record of the pre-hospital report form (when patient is brought in by ambulance) shall be attached to the emergency room record.
(7) All entries in a patient's medical record shall be dated, timed and authenticated.
(a) Authentication of an entry requires the use of a unique identifier, including but not limited to a written signature or initials, code, password, or by other computer or electronic means that allows identification of the individual responsible for the entry.
(b) Systems for authentication of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document after it has been transcribed or generated.
(8) The following records shall be maintained in written or computerized form for the time period specified:
(a) Permanent:
(A) Patient's register, containing admissions and discharges;
(B) Patient's master index;
(C) Register of all deliveries, including live births and stillbirths;
(D) Register of all deaths; and
(E) Register of operations.
(b) Seven years:
(A) Register of outpatients; and
(B) Emergency room register.
(c) Blood banking register shall be retained for 20 years.
(9) The completion of the medical record shall be the responsibility of the attending qualified member of the medical staff. Any licensed health care practitioner responsible for providing or evaluating the service provided shall complete and authenticate those portions of the record that pertain to their portion of the patient's care. The appropriate individual shall authenticate the

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history and physical examination, operative report, progress notes, orders and the summary. In a hospital using interns, such orders must be according to policies and protocols established and approved by the medical staff. An authentication of a licensed health care practitioner on the face sheet of the medical record does not suffice to cover the entire content of the record:
(a) Medical records shall be completed by a licensed health care practitioner and closed within four weeks following the patient's discharge.
(b) If a patient is transferred to another health care facility, transfer information shall accompany the patient. Transfer information shall include but is not limited to:
(A) The name of the hospital from which they were transferred;
(B) The name of physician or other health care practitioner to assume care at the receiving facility;
(C) The date and time of discharge;
(D) The current medical findings;
(E) The current nursing assessment;
(F) Current medical history and physical information;
(G) Current diagnosis;
(H) Orders from a physician or other licensed health care practitioner for immediate care of the patient;
(I) Operative report, if applicable;
(J) TB test, if applicable; and
(K) Other information germane to patient's condition.
(c) If the discharge summary is not available at time of transfer, it shall be transmitted to the new facility as soon as it is available.
(10) Diagnoses and operations shall be expressed in standard terminology. Only abbreviations approved by the medical staff may be used in the medical records.
(11) Medical records shall be filed and indexed. Filing shall consist of an alphabetical master file with a number cross-file. Indexing is to be done according to diagnosis, operation, and qualified member of the medical staff, using a system such as the International or Standard nomenclature systems.
(12) Medical records are the property of the hospital. The medical record, either in original, electronic or microfilm form, shall not be removed from the hospital except where necessary for a judicial or administrative proceeding. Treating and attending physicians shall have access to medical records. When a hospital uses off-site storage for medical records, arrangements must be made for delivery of these records to the hospital when needed for patient care or other hospital activities. Precautions must be taken to protect patient confidentiality.
(13) Authorized personnel of the Division shall be permitted to review medical records and patient registers as necessary to determine compliance with health care facility licensing laws.
(14) Medical records shall be kept for a period of at least 10 years after the date of last discharge. Original medical records may be retained on paper, microfilm, electronic or other media.
(15) Medical records shall be protected against unauthorized access, fire, water and theft.
(16) If a hospital changes ownership, all medical records in original, electronic or microfilm form shall remain in the hospital and it shall be the responsibility of the new owner to protect and maintain these records.

(17) If a hospital closes, its medical records and the registers required under section (8) of this rule may be delivered and turned over to any other hospital in the vicinity willing to accept and retain the same as provided in section (12) of this rule. A hospital which closes permanently shall follow the procedure for Division and public notice regarding disposal of medical records under OAR 333-500-0060.
(18) All original clinical records or photographic or electronic facsimile thereof, not otherwise incorporated in the medical record, such as X-rays, electrocardiograms, electroencephalograms, and radiological isotope scans shall be retained for seven years after a patient's last exam date if professional interpretations of such graphics are included in the medical records. Mammography images shall be retained for 10 years after a patient's last exam date.
(19) If a qualified medical record practitioner, RHIT (Registered Health Information Technician) or RHIA (Registered Health Information Administrator) is not the Director of the Medical Records Department, periodic and at least annual consultation must be provided by a qualified medical records consultant, RHIT/RHIA. The visits of the medical records consultant shall be of sufficient duration and frequency to review medical record systems and assure quality records of the patients. The contract for such services shall be made available to the Division.
(20) A current written policy on the release of medical record information including a patient's access to his or her medical record shall be maintained in the medical records department.
(21) A hospital is not required to keep a medical record in accordance with this rule for a person referred to a hospital ancillary department for a diagnostic procedure or health screening by a private physician, dentist, or other licensed health care practitioner acting within his or her scope of practice.
(22) Pursuant to ORS 441.059, the rules of a hospital that govern patient access to previously performed X-rays or diagnostic laboratory reports shall not discriminate between patients of chiropractic physicians and patients of other licensed health care practitioners permitted access to such X-rays and diagnostic laboratory reports.
(23) Nothing in this rule is meant to prohibit or discourage a hospital from maintaining its records in electronic form.
Stat. Auth: ORS 441.025
Stats. Implemented: ORS 441.025

OAR 333-505-0055
Discharge Planning Requirements
(1) As used in this rule:
(a) For purposes of subsection (2)(b) of this rule, "lay caregiver" means an individual who, at the request of a patient, agrees to provide aftercare to the patient in the patient's residence.
(b) For purposes of subsection (2)(c) of this rule, "lay caregiver" means:
(A) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient;
(B) For a patient who is 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.
(c) "Peer support" means a peer support specialist, peer wellness specialist, family support specialist or youth support specialist as those terms are defined in ORS 414.025 and who are certified in accordance with OAR chapter 410, division 180.

(d) "Publicly available" means posted on the hospital's website and provided to each patient and to the patient's lay caregiver in written form upon admission to the hospital or emergency department and upon discharge from the hospital or release from the emergency department. The written form provided to a patient and lay caregiver may be a summarized version of the policy that is clear and easily understood.
(2) A hospital shall adopt, maintain and follow written policies on discharge planning and termination of services in accordance with these rules and 42 CFR 482.43. The policies shall include but are not limited to:
(a) A plan for continuity of patient care following discharge including:
(A) An assessment of the patient's ability for self-care;
(B) An opportunity for the patient to designate a lay caregiver;
(C) An opportunity for the patient, and if designated the lay caregiver, to participate in discharge planning;
(D) Instructions or training provided to the patient and lay caregiver prior to discharge for the lay caregiver to provide assistance with activities of daily living, medical or nursing tasks such as wound care, administering medications, or the operation of medical equipment, or other assistance relating to the patient's condition; and
(E) A requirement to notify the lay caregiver that patient is being discharged or transferred; and
(b) For patients hospitalized for mental health treatment, a plan to:
(A) Have a licensed health care professional involved with treating the patient, encourage the patient to designate a lay caregiver and sign an authorization form for the disclosure of information that is necessary for a lay caregiver to participate in the patient's discharge planning and to provide appropriate support to the patient following discharge as well as an explanation of:
(i) The benefits of involving a lay caregiver including participating in the patient's discharge planning in order to provide appropriate support measures;
(ii) Only the minimum information necessary will be shared;
(iii) The benefits disclosing health information will have on the ability of the patient to see positive outcomes; and
(iv) The ability to rescind the authorization at any time;
(B) Assess the patient's risk of suicide with input from the patient's lay caregiver, if applicable;
(C) Assess the long-term needs of the patient which include but are not limited to:
(i) Community-based services;
(ii) Capacity for self-care; and
(iii) To the extent practicable, whether the patient can be properly cared for in the place where the patient resided at time of admission;
(D) Develop a process to coordinate the patient's care and transition the patient to outpatient treatment that may include community-based providers, peer support, lay caregivers or other individuals who can implement the patient's care plan; and
(E) Schedule a follow-up appointment for no later than seven days after discharge. If a follow-up appointment cannot be scheduled within seven days, the hospital must document why.
(3) Discharge policies developed in accordance with this rule:

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(a) Must be publicly available;
(b) Must specify the requirements for documenting who is designated by the patient as the lay caregiver and the details of the discharge plan;
(c) May incorporate established evidence based practices;
(d) Must ensure that discharge planning is appropriate to the needs and acuity of the patient and the abilities of the lay caregiver;
(e) Must not delay a patient's discharge or transfer to another facility; and
(f) Must not require the disclosure of protected health information without obtaining a patient's consent as required by state and federal laws.
(4) In accordance with ORS 192.567, a health care provider may use or disclose protected health information to a person if the health care provider, consistent with standards of ethical conduct, believes in good faith that the disclosure is necessary to prevent or lessen a serious threat to the health or safety of any person or the public, and if the information is disclosed only to a person who is reasonably able to prevent or lessen the threat, including the target of the threat.
Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 413.273, 441.025, 441.196 & 441.198

Division 520
HOSPITAL~~S,~~ SERVICES~~GENERALLY~~

333-520-0070
Emergency Department and Emergency Services
(1) As used in this rule:
(a) "Behavioral health assessment" and "behavioral health clinician" has the meaning given those terms in section (4), 2017 Oregon Laws, Chapter 273;
(b) "Behavioral health crisis" has the meaning given that term in section (2), 2017 Oregon Laws, Chapter 272;
(c) "Caring contact" means a brief communication with a patient that starts during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary;
(d) "Lay caregiver" means:
(i) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient;
(ii) For a patient who is 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675; or
(iii) For a patient who is 14 years or older, and who has not designated a caregiver, an individual to whom a health care provider may disclose protected health information without a signed authorization under ORS 192.567.
(2~~1~~) Hospitals classified as general and low occupancy acute care shall have an emergency department that provides emergency services.
(3~~2~~) A hospital with an emergency department shall:

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(a) Provide emergency services 24 hours a day including providing immediate life saving intervention, resuscitation, and stabilization;
(b) Have a licensed health care practitioner with admitting privileges on-call, 24 hours a day;
(c) Have at least one registered nurse, appropriately trained to provide emergency care within the emergency service area;
(d) Have adequate medical staff and other ancillary personnel necessary to provide emergency care either present in the emergency service area or available 24 hours a day in adequate numbers to respond promptly;
(e) Ensure that when surgical, laboratory, and X-ray procedures are indicated and ordered, due regard is given to promptness in carrying them out;
(f) Ensure that it has items for resuscitation, stabilization, and basic emergency medical care, including airway equipment and cardiac resuscitation medications and supplies for adults, children and infants;
(g) Have a communication system and personnel available 24 hours a day to ensure rapid communication with ambulances and departments of the hospital including, but not limited to, X-ray, laboratory, and surgery;
(h) Have a plan for emergency care based on community needs and on hospital capabilities which sets forth policies, procedures and protocols for prompt assessment, treatment and transfer of ill or injured persons, including specifying the response time permissible for medical staff and other ancillary personnel;
(i) Provide for the prompt transfer of patients, as necessary, to an appropriate facility in accordance with transfer agreements, approved trauma system plans, consideration of patient choice, and consent of the receiving facility;
(j) Have written transfer agreements for the care of injured or ill persons if the hospital does not provide the type of care needed;
(k) Ensure that personnel are able to provide prompt and appropriate instruction to ambulance personnel regarding triage, treatment and transportation;
(l) Develop, maintain, and implement current written policies and procedure that include clearly-defined roles, responsibilities, and reporting lines for emergency service personnel;
(m) Maintain emergency records in accordance with OAR 333-505-0050;
(n) Establish a committee of the emergency department staff who shall at least quarterly, review emergency services by evaluating the quality of emergency medical care given, and engage in ongoing development, implementation, and follow-up on corrective action plans; and
(o) Ensure it provides appropriate training programs for hospital emergency service personnel.
(4) A hospital shall adopt, maintain and follow written policies that pertain to the release of a patient from the emergency department who was seen for a behavioral health crisis. The policy shall include but is not limited to:
(a) A requirement to encourage the patient to designate a lay caregiver and sign an authorization form in accordance with OAR 333-505-0055(2)(b)(A);
(b) A requirement to conduct a behavioral health assessment by a behavioral health clinician;
(c) If indicated by the behavioral health assessment, a requirement to conduct a best practices suicide risk assessment, and if indicated develop a safety plan and lethal means counseling with the patient and the designated caregiver;

(d) A requirement to assess the long-term needs of the patient which includes, but is not limited to:
(i) The patient's need for community based services;
(ii) The patient's capacity for self-care; and
(iii) Appropriate patient care in the place where the patient resided at the time the patient presented at the emergency department;
(e) A process to coordinate care through the deliberate organization of patient care activities which may include notification to a patient's primary care provider, referral to other provider including peer support as defined in OAR 333-505-0055, follow-up after release from the emergency department, or creation and transmission of a plan of care with the patient and other provider;
(f) A process for case management that includes a systematic assessment of the patient's medical, functional and psychosocial needs and may include an inventory of resources and supports recommended by a behavioral health clinician, indicated by a behavioral health assessment, and agreed upon by the patient;
(g) A process to arrange a caring contact or other follow-up contact with another provider or other effort to successfully transition a patient to outpatient services. The follow-up contact or caring contact:
(A) May be done through contracts with a qualified community-based provider, including peer support, or by a provider from a suicide prevention hotline;
(B) May be conducted in person, via telemedicine or by phone; and
(C) Must be attempted within 48 hours of release if a behavioral health clinician has determined a patient has attempted suicide or experienced suicidal ideation; and
(h) A follow-up appointment with a clinician must be made within seven calendar days of release. If a follow-up appointment cannot be scheduled within this time frame, the hospital must document why.
(5) Policies developed in accordance with section (4) of this rule shall comply with OAR 333-505-0055 subsection (2)(a) paragraphs (B) through (D) and section (3).
(6~~3~~) If a hospital is also designated or categorized as a trauma hospital under ORS 431.607 through 431.671, the hospital shall:
(a) Comply with the applicable provisions in OAR chapter 333, division 200 through 205;
(b) Report trauma data to the State Trauma Registry in accordance with the requirements of the Division; and
(c) Fully cooperate with the approved area trauma system plan.
(7~~4~~) An officer or employee of a general or low occupancy acute care hospital licensed by the Division may not deny a person an appropriate medical screening examination needed to determine whether the person is in need of emergency medical services if the screening is within the capability of the hospital, including ancillary services routinely available to the emergency department.
(8~~5~~) An officer or employee of any hospital licensed by the Division may not deny services to a person diagnosed by a physician as being in need of emergency medical services because the person is unable to establish the ability to pay for the services if those emergency medical services are customarily provided at the hospital.

(<u>9</u>~~1~~~~6~~) A mental or psychiatric hospital shall assess and provide initial treatment to a person that presents to the hospital with an emergency medical condition, as that term is defined in 42 CFR 489.24. The hospital shall admit the person if the emergency medical condition falls within the specialty services provided by the hospital under OAR chapter 333, division 525.
Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015

DIVISION 525
MENTAL OR PSYCHIATRIC HOSPITAL

333-525-0000
Mental or Psychiatric Hospital
A hospital classified as mental or psychiatric shall:
(1) Be devoted primarily to the diagnosis and treatment of mentally ill persons.
(2) Have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning, including:
(a) A clinical director, service chief, or equivalent who:
(A) Is qualified to provide the leadership required for an intensive treatment program;
(B) Meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry;
(C) Monitors and evaluates the quality and appropriateness of services and treatment provided by the medical staff; and
(D) Supervises inpatient psychiatric services.
(b) Doctors of medicine or osteopathy and other appropriate professional personnel available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a licensed hospital.
(c) A director of psychiatric nursing services who:
(A) Is a registered nurse with a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing Accrediting Commission, or the Commission on Collegiate Nursing Education, or is qualified by education and experience in the care of the mentally ill; and
(B) Demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.
(d) Registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.
(e) The availability of a registered professional nurse 24 hours each day.

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(f) The availability of staff to provide other psychological services to meet the needs of the patients.
(g) A director of social services who:
(A) Has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill; and
(B) Monitors and evaluates the quality and appropriateness of social services furnished.
(h) At least one staff member with a master’s degree in social work if the director of social services does not have such a degree.
(i) Social service staff with responsibilities that include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.
(j) Qualified therapists, support personnel, and consultants adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.
(k) In a satellite as defined in OAR 333-500-0010(46)(b), the prompt availability of at least one psychiatrist to provide emergency psychiatric services or other psychiatric services to meet the needs of the patients 24 hours each day in person or using telemedicine technology.
(3) Have a therapeutic activities program that is appropriate to the needs and interests of patients and directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
(4) Maintain medical records in a manner that permits determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized. A patient's medical record shall include:
(a) The patient's legal status;
(b) The provisional or admitting diagnosis, including the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
(c) The reasons for admission as stated by the patient or others significantly involved;
(d) The social service records, including reports of interviews with patients, family members, and others, including an assessment of home plans and family attitudes, and community resource contacts as well as a social history;
(e) When indicated, a complete neurological examination recorded at the time of the admission physical examination;
(f) Documentation of all active therapeutic efforts; and
(g) A discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.
(5) Have a psychiatrist perform a psychiatric evaluation of each patient that:
(a) Is completed within 60 hours of admission;
(b) Includes a medical history;
(c) Contains a record of mental status;
(d) Notes the onset of illness and the circumstances leading to admission;
(e) Describes attitudes and behavior;

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(f) Estimates intellectual functioning, memory functioning, and orientation; and
(g) Includes an inventory of the patient's assets in descriptive, not interpretative, fashion.
(6) Develop a written individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities that includes:
(a) A substantiated diagnosis;
(b) Short-term and long-range goals;
(c) The specific treatment modalities utilized;
(d) The responsibilities of each member of the treatment team; and
(e) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.
(7) Ensure that progress notes are recorded by:
(a) The doctor of medicine or osteopathy responsible for the care of the patient; and
(b) Nurses, social workers and, when appropriate, others significantly involved in active treatment modalities.
(8) The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.
(9) Provide discharge planning in accordance with OAR 333-505-0055~~0030~~.
(10) Comply with the applicable rules of the Authority's Health Systems Division, Mental Health Services, OAR chapter 309, divisions 31 and 33.
Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.025

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Notes for School Psychologist Article.

If you're thinking about suicide, of are worried about a friend or loved one, or would like emotional support, the Lifeline network is available 24/7 across the United States. Call 1-800-273-8255. A skilled, trained crisis worker who works at the Lifeline (in Oregon, Lines for Life) will answer the phone. This person will listen to you, provides support and share any resources that may be helpful

The Oregon Alliance to Prevent Suicide

*Youth suicide is a tragedy that can impact any family, school, and community. In Oregon, 103 youth ages 10 to 24 years died by suicide in 2017, making suicide the second leading cause of death (behind unintentional death) among youth in that age bracket. (*Oregon Violent Death Reporting System, 2018*)*

In 2014, the Oregon State Legislature mandated development of a 5-year plan to address Oregon's high rate of suicide among individuals age 10 through 24-years-old. The Oregon **Youth Suicide Intervention and Prevention Plan** was signed by the Oregon Health Authority and submitted to the Legislature in January 2016.

Embedded throughout the plan is a belief that it is crucial to support Oregon's youth and families by:

- Promoting a sense of **hope** and highlighting resilience.
- Normalizing **help**-seeking behaviors, and supporting individuals and systems to provide help
- Engaging individuals and communities in the **healing** process after an attempt or suicide
-

The Plan established the Oregon Alliance to Prevent Suicide (Alliance), which is charged with overseeing implementation of the plan and evaluating outcomes related to suicide prevention in Oregon. Alliance members are appointed by the Oregon Health Authority to develop a public policy agenda for suicide intervention and prevention across agencies, systems and communities. The four strategic directions of the YSIPP are:

Healthy and Empowered Communities – Integrate and coordinate suicide prevention activities across multiple sectors and settings. Formed the Alliance, promoted adoption of Zero Suicide as an organizational goal for health systems, developed strategies to expand communications about suicide prevention

Clinical and Preventive Services - Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors. Schools are implementing upstream prevention programs such as Sources of Strength and the Good Behavioral Game. Across the state 1291 school perspnnel have completed the Youth Mental Health First Aid training. Legislation is being proprosed to

require that all behavioral health professionals in Oregon receive training in suicide prevention, intervention and treatment.

Treatment and support services - Promote suicide prevention as a core component of health care services. Successfully advocated for legislation for continuity of care, to improve aftercare for post discharge from emergency dept., supported communities to develop comprehensive postvention plans, Promote the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide continuity of care and support a defined patient population.

Surveillance, research and evaluation – the Alliance is a research practice partnership with the University of Oregon, Suicide Prevention Lab, the Oregon Health Authority and the Association of Oregon Community Mental Health Programs.

How to connect with the efforts of the Alliance

How School Psychologists can connect with the Alliance--

First, we encourage you to get involved locally. There are coalitions around the state working to prevent suicide and to support effective intervention and postvention. Join your local coalition. See the Alliance website Oregon map to find an organization near you.

If you are interested in getting involved with the work of the Alliance, you may want to join one of our ongoing workgroups or committees. Contact Annette for more information.

Outreach and Awareness

The Outreach and Awareness Committee is responsible for action items in the Youth Suicide Prevention and Intervention Plan that have to do with to messaging about suicide prevention, communication among people and organizations working in the field of youth suicide prevention, intervention and postvention and publicity about suicide issues.

Workforce Development

The Workforce Development Committee is responsible for researching and recommending programs to improve the skills of physical health providers, those serving people with mental health and substance use challenges, and school staff.

Schools

The Schools Committee is responsible for researching and making recommendations on programs and processes for improving suicide prevention, intervention and postvention in Oregon schools and colleges.

Continuity of Care

Notes for School Psychologist Article.

The Continuity of Care Committee is responsible for researching and making recommendations for making sure care is available and effective as youth transition across types of care, for example from emergency departments to outpatient care with a mental health provider in the community.

Data And Evaluation

The Data and Evaluation Committee is responsible for working with the University of Oregon for monitoring completion of the Youth Suicide Intervention and Prevention Plan and tracking risk factors for suicide in Oregon.

A couple of key events that school psychologists would be interested in:

I. **2019 Oregon Suicide Prevention Conference** (pdf and word version of save the date included—love to see this in the article) – March 13 – 15, 2019, Sunriver Resort, Sunriver, OFor more information about this conference, contact **Asa Wright**, Lines for Life Prevention Projects Coordinator | 971.247.9072 or asaw@linesforlife.org

1) **Critical Role of Family Support in LGBTQ Suicide Prevention-A one-day intensive with Dr. Caitlin Ryan of the Family Acceptance Project**. Friday, April 5, 2019 9 a.m. to 4:30 p.m., Lane Community College, Eugene, Oregon Email amarcus@aocmhp.org for more information. (Free, lunch provided)

The Family Acceptance Project® is a research, intervention, education and policy initiative that works to prevent health and mental health risks for lesbian, gay, bisexual and transgender (LGBT) children and youth, including suicide, homelessness and HIV – in the context of their families, cultures and faith communities. We use a research-based, culturally grounded approach to help ethnically, socially and religiously diverse families to support their LGBT children.

Learn about how you can put the research of the Family Acceptance Project into practice by sharing information about an evidence-based family model of wellness, prevention and care to strengthen families and promote positive development and healthy futures for LGBT children and youth.

Notes for School Psychologist Article.

Continuity of Care Committee Updates for January 18, 2018 SPA Meeting

- Action item, “Suggest EBPs (to ODE/ESDs/school districts) for mental health awareness and suicide prevention training programs for staff and students” was transferred to Schools Committee.

- COC members volunteered for the RACs on **HB 3090 and 3091** implementation. Public comment period for 3091 is open until 1/2/2019. Visit http://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx and click on section about Defining Coordinated Care and Case Management to see proposed rules and all comments submitted currently. Alliance Members have submitted comment letters although more comments are welcome. For 3090, any Alliance Members who would like to make comments, be informed of proposed rule filings, or other action can contact Mellony Bernal MELLONY.C.BERNAL@dhsoha.state.or.us to get on the mailing list.

- On January 5, 2018, COC members met with the Hospital Association (OAHHS) to outline and discuss requests for standards of care for people in behavioral health crisis who are discharged from hospitals and suicide risk assessments. This meeting resulted in agreement that OAHHS, Alliance members and other identified individuals will develop and work collaboratively on multiple brochures to speak to separate audiences (i.e. patients, families or lay caregivers, and providers) about standards of care for people in behavioral health crisis who are discharged from hospitals and suicide risk assessments. These brochures will be made available at multiple times in hospital settings. COC members have a follow up meeting with Alliance members on January 19, 2018 for continued collaboration.

- Samples of MOUs concerning transitions from acute care back to school to the ESDs. COC members will develop a plan for an environmental scan of existing samples.

- COC will move action item, “Recruit hospital to implement a Caring Contact intervention pilot in a non-ED pilot community” to 2019 timeline due to what is happening with 3090 and 3091.

HB2023 - requires hospitals to adopt and enforce policies for discharging patients who are hospitalized for mental health treatment, meaning patients admitted to a psychiatric inpatient hospital for treatment, and make the policies developed by each hospital publicly available.

HB 3091 - Although existing law requires health carriers to cover services in emergency settings and to adhere to mental health parity requirements, certain patients were not receiving behavioral health assessments as part of care during a behavioral health crisis and were not adequately transitioning from an acute care setting to community-based care. House Bill 3091 provides clarity regarding the services to be provided during these events and requires the Department of Consumer and Business Services to adopt rules defining coordinated care and case management to ensure patients with coverage through coordinated care organizations or the commercial health insurance market are properly assessed and receive the support necessary for transition to community-based care.

HB 3090 - states that hospitals shall adopt, maintain and follow written policies that pertain to the release of a patient from the emergency department who was seen for a behavioral health crisis.

Workforce Committee Summary

At our meeting the primary objectives were to

- Review our goals and progress on action plan (from June 2017)
- Determine our next steps, roles and responsibilities to move action items forward

Action items that came from our meeting:

- Send out a new link for SB48 materials to Alliance members and Workforce
- Consider finding or develop a check list of things to consider when deciding which suicide prevention/intervention training to attend or invest in (this to be continued at the committee's next meeting).
- Committee will continue the discussion regarding evaluation of assessment tools, John Seeley agreed to take the lead on this.
- Training the DHS Staff – with the leads for this being Deborah, Ann and Annette
    - We have met twice DHS Child Welfare/Alliance (Annette, Ann, & myself). The discussion has been about suicide prevention training and skill building.
      Below is a summary from our meeting that was compiled by Molly Miller
        - Review the intersectionality with DHS Child Welfare and suicide by conducting a review of cases
        - Developing/customizing training for staff, families, and foster parents based on what we learned in our case review, and integrating that information into what we already know
        - Identifying services and resources for families, inclusive of finding providers with specific knowledge related to this topic (DMHP, mental health, providers in the office, community outreach, including family support specialists, etc.)
        - Unifying this issue with an overall effort to provide better mental health services to children

- Operationalizing the plan by discussing messaging to staff, working with community partners who enhance efforts already in place, creating procedure, and agreeing on a mission statement (purpose) and discussing time frames
- Creating a method to measure change