Healthy People 2020: Who’s Leading the Leading Health Indicators?
Who’s Leading the Leading Health Indicators?

• **Leading Health Indicators are:**
  
  o Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses
  
  o Linked to specific Healthy People objectives
  
  o Intended to motivate action to improve the health of the entire population

1200 Healthy People objectives

LHIs are a subset of Healthy People objectives
Who’s Leading the Leading Health Indicators?

Featured Speakers:

• **Don Wright, MD, MPH** – Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

• **Richard McKeon, PhD** – Suicide Prevention Branch Chief, Division of Prevention, Traumatic Stress, and Special Programs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

• **Julie Goldstein Grumet, PhD** – Director of Health and Behavioral Health Initiatives, Suicide Prevention Resource Center, Director, Zero Suicide Institute, Education Development Center

• **Brian Ahmedani, PhD, LMSW** – Director, Center for Health Policy and Health Services Research, Director of Research, Behavioral Health Services, Henry Ford Health System
Don Wright, MD, MPH
Deputy Assistant Secretary for Health Director
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
### Mental Health

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Mental Health Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State of well-being</td>
<td>• Health conditions characterized by alterations in thoughts, mood, and/or behaviors</td>
</tr>
<tr>
<td>• Individuals can:</td>
<td>• Can have harmful and long-lasting effects</td>
</tr>
<tr>
<td>- Realize their own abilities</td>
<td>- High psychosocial and economic costs</td>
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<tr>
<td>- Cope with normal stresses of life</td>
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<tr>
<td>- Work productively and fruitfully</td>
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<tr>
<td>- Contribute to their own community</td>
<td></td>
</tr>
<tr>
<td>• May impact their family, relationships, and ability to be productive</td>
<td>• Association between mental health disorders and physical health</td>
</tr>
</tbody>
</table>
Risk Factors Related to Mental Health

• **Indicators of mental health**
  • Emotional well-being
  • Psychological well-being
  • Social well-being

• **Risk factors linked to mental health**
  • Race/ethnicity
  • Sex
  • Gender
  • Age
  • Income
  • Education
  • Sexual orientation
  • Geographic location
Mental Health – Across the Lifespan

• Children and Adolescents
  • Nearly 20% experience a mental health disorder
  • Onset can be as early as 6 years old
  • Early treatment and diagnosis of mental health disorders may help lower the risk for unhealthy and unsafe behaviors

• Adults
  • About 19% live with a mental health disorder
  • Mental health disorders affect young adults (18 to 25 years) more than other adult age groups

• Preventing mental health disorders and promoting good mental health can create supportive living environments for people to adopt and maintain healthy lifestyles
Mental Health
Leading Health Indicators

• Reduce the suicide rate (MHMD-1)

• Adolescents with a major depressive episode (MHMD-4.1)
Suicide Rate by Race/Ethnicity, 2017

Rate per 100,000 (age-adjusted)

NOTE: Data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death. American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Data are age-adjusted to the 2000 standard population.

Obj. MHMD-1 Decrease desired
Suicide Rate by Age, 2017

NOTE: = 95% confidence interval. Data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death. Data for the total population are age adjusted to the 2000 standard population. SOURCE: National Vital Statistics System–Mortality (NVSS–M), CDC/NCHS; and Bridged–race Population Estimates, CDC/NCHS and Census.
Suicide and Major Depressive Episode (MDE) among Adolescents by Sex, 2017

NOTE: Data are for adolescents aged 12-17 who died by suicide or reported having a Major Depressive Episode (MDE) in the past 12 months. Suicide data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death.


Related Obj. MHMD-1; Obj. MHMD-4.1,
Decrease desired
Major Depressive Episode (MDE) among Adolescents, 2017

- **NOTE:** *= 95% confidence interval. *2008 Total = HP2020 baseline. Data are for adolescents aged 12-17 years who reported having a Major Depressive Episode (MDE) in the past 12 months. American Indian includes Alaska Native. Native Hawaiian includes other Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.

**SOURCE:** National Survey on Drug Use and Health (NSDUH), SAMHSA.
The views, opinions, and content expressed in this publication do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
PROBLEM  SUICIDE RATES INCREASED IN ALMOST EVERY STATE.

Suicide rates rose across the US from 1999 to 2016.

Increase 38 - 58%
Increase 31 - 37%
Increase 19 - 30%
Increase 6 - 18%
Decrease 1%

Percentage increases in state suicide rates

Top 10

<table>
<thead>
<tr>
<th>State</th>
<th>Sex</th>
<th>Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period)</th>
<th>Modeled AAPC†</th>
<th>Current State Rank</th>
<th>Overall Rate Change (State Rank)</th>
<th>Overall Percent Change (State Rank)</th>
</tr>
</thead>
</table>
SAMHSA Programs, Efforts, Initiatives

- Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention and Intervention Program
  - *Evaluations show program lowers rates of suicide and suicide attempts with increased longevity and robustness when duration of grant is increased
- GLS Campus Suicide Prevention Grant Program
- Zero Suicide in Health Systems
- Suicide Prevention Resource Center
- National Strategy for Suicide Prevention grants
- Native Connections (Tribal Behavioral Health)
- National Suicide Prevention Lifeline
- Crisis Center Follow-up grants
- SMVF TA- Mayor’s and Governor’s Challenge
- Family Toolkit
National Strategy for Suicide Prevention

American Association of Suicidology

2015 Annual Meeting
THE IMPACT OF GLS SUICIDE PREVENTION PROGRAM ON YOUTH SUICIDAL BEHAVIOR

Lucas Godoy Garraza (ICF International); Christine Walrath (ICF International); David Goldston (Duke CSSPI); Hailey Reid (ICF International), Richard McKeon (SAMHSA)
Proxy for GLS Program Implementation

>39,000 Training Events

>1.4M Trainees

More than 96% of State and Tribal grantees conduct Gatekeeper Trainings

*data through July 2018
Improving Post Discharge Safety

• ED SAFE demonstrated reduction in suicidal behavior for suicidal people discharged from ED’s doing telephonic follow up. SafeVet replicated this finding.

• White Mountain Apache/JHU Center for American Indian Health almost 40% reduction in suicides from 2006-2012—centerpiece is tribally mandated reporting and follow up.
“Celebrating Life”
&
“Empowering Our Spirits

Preventing Suicide in White Mountain Apache Youth
Longer-term Impact on Youth Suicide Mortality

Sustained impact after consecutive years of GLS programming

![Graph showing the impact of GLS programming on youth suicide mortality over time.](image-url)
Greater impact seen in rural areas

• 2.4 fewer deaths per 100,000 youth 2 years after GLS implementation

• 20% stronger effect in rural counties than in non-rural counties or 1 fewer death per 244,000 youth

The decrease in youth suicide mortality appears to be stronger in rural communities
24 Cities Participating in Mayor’s Challenge

- Albuquerque, NM
- Atlanta, GA
- Austin, TX
- Billings, MT
- Clarksville, TN
- Columbus, OH
- Detroit, MI
- Helena, MT
- Hillsborough County, FL
- Houston, TX
- Jacksonville, FL
- Kansas City, MO
- Las Vegas, NV
- Los Angeles, CA
- Manchester, NH
- Mecklenburg County, NC
- Oklahoma City, OK
- Phoenix, AZ
- Reno, NV
- Richmond, VA
- Suffolk County, NY
- Topeka, KS
- Tulsa, OK
- Warwick, RI

**Mayors Challenge Sites**
- Albuquerque, NM
- Atlanta, GA
- Austin, TX
- Billings, MT
- Clarksville, TN
- Columbus, OH
- Detroit, MI
- Helena, MT
- Hillsborough County, FL
- Kansas City, MO
- Las Vegas, NV
- Los Angeles, CA
- Manchester, NH
- Mecklenburg County, NC
- Oklahoma City, OK
- Phoenix, AZ
- Reno, NV
- Richmond, VA
- Suffolk County, NY
- Topeka, KS
- Tulsa, OK
- Warwick, RI

**Crisis Intercept Mapping Sites**
- Albuquerque, NM
- Atlanta, GA
- Clarksville, TN
- Kansas City, MO
- Helena, MT
- Houston, TX
- Las Vegas, NV
- Los Angeles, CA
- Manchester, NH
- Mecklenburg County, NC
- Richmond, VA
- Truckee Meadows, NV
Rural Primary Care Toolkit
To Live to See the Great Day that Dawns

To Live To See the Great Day That Dawns:
Preventing Suicide by American Indian and Alaska Native Youth and Young Adults

SAMHSA
Substance Abuse and Mental Health Services Administration
National Suicide Hotline Improvement Act:
SAMHSA Report to FCC

Richard McKeon, Ph.D.
Suicide Prevention Branch Chief
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
It’s time for a national *mental health* Emergency Medical Services (EMS) system.
Potential Impact of N11

- Based on SAMHSA’s experience with national and state crisis intervention efforts over the past 18 years, and informed by a meeting of experts and stakeholders in mental health, crisis intervention, emergency services and suicide prevention that SAMHSA convened November 29 to 30, 2018, our judgment is that an N11 national suicide prevention number has the potential to play a key role in improving national crisis intervention and suicide prevention efforts; if the launch of a new number is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology systems, and an ongoing commitment to data driven quality improvement.
Ubiquitous and inexpensive technology is changing nearly every other industry.
SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

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www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)
Suicide Prevention: Resources for the Community

Julie Goldstein Grumet, PhD
Director, Health and Behavioral Health Initiatives
Suicide Prevention Resource Center
Director, Zero Suicide Institute

July 18, 2019
Funding and Disclaimer

The Suicide Prevention Resource Center at EDC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 5U79SM062297.

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Suicide Prevention Resource Center

The national Suicide Prevention Resource Center (SPRC) is your one-stop source for suicide prevention. We help you develop, deliver, and evaluate evidence-informed suicide prevention programs.

What we offer
• Best practice models
• Toolkits
• Online trainings
• Research summaries and more!

Who we serve
• Organizations
• Communities
• Agencies
• Systems

CONNECT WITH US
www.sprc.org
@SuicidePreventionResourceCenter
@SPRCTweets
Visit SPRC.org

Sign up for SPRC’s Weekly Spark newsletter for the latest news, research, and announcements.

Discover how to apply suicide prevention best practices with SPRC’s Effective Suicide Prevention Model.

Explore a library of suicide prevention programs with evidence of effectiveness.

Learn at your own pace with online courses, learning labs, and brief videos.

Access a wealth of resources, including toolkits, fact sheets, success stories, and more!

Find information on suicide prevention efforts in your state.
Effective Prevention

EFFECTIVE SUICIDE PREVENTION

STRATEGIC PLANNING

KEYS TO SUCCESS

COMPREHENSIVE APPROACH
A Comprehensive Approach to Suicide Prevention
Guiding Principles

KEYS TO SUCCESS

- Engaging People with Lived Experience
- Partnerships and Collaboration
- Safe and Effective Messaging and Reporting
- Culturally Competent Approaches
- Evidence-Based Prevention
Strategic Planning

THE STRATEGIC PLANNING APPROACH TO SUICIDE PREVENTION

STEP 1: Describe the problem and its context

STEP 2: Choose long-term goals

STEP 3: Identify key risk and protective factors

STEP 4: Select or develop interventions

STEP 5: Plan the evaluation

STEP 6: Implement, evaluate, and improve
Effective Prevention

- Effective prevention requires strategic planning.
- Suicide is multidimensional. No single approach will reduce suicide.
- Strategic planning offers you the time to learn about suicide in your community – use data to determine where to focus your efforts.
- Successful endeavors incorporate:
  - Lived experience
  - Partnerships and collaboration
  - Safe and effective messaging
  - Culturally competent approaches
  - Evidence-based prevention
Suicide is a Complex, Multidimensional Problem

- Bundle of interventions
- Prevention and intervention efforts must be sustained
- Data driven decisions
- Continuous quality improvement
Why Evaluation Is Important

Evaluating your program will help you:

• Identify and solve problems
• Determine progress toward your goals
• Show partners, stakeholders, policymakers, funders, and the community the value of suicide prevention
• Decide on how to enhance or expand your suicide prevention efforts

Key aspects of evaluating your program:

• Hire an evaluator (if you don’t have one on staff)
• Involve the agencies, organizations, and people who will be collecting or providing data for the evaluation
• Research the suicide problem in your community, including risk and protective factors
• Develop a logic model that shows how your planned activities will lead to your long-term goals
• Monitor progress and results
• Analyze findings and use them to enhance your suicide prevention efforts

Gathering data can be challenging – Don’t let PERFECT be the enemy of GOOD
PREVENTION IN PRACTICE
Success Stories from the Field

https://go.edc.org/PiP

Surveillance
Success Stories

https://go.edc.org/Surveillance
Resources and Websites

Suicide Prevention Resource Center:

- http://www.sprc.org/effective-prevention/comprehensive-approach
- http://www.sprc.org/virtuallearninglab/state-virtual-learning-lab
- http://www.sprc.org/states

Zero Suicide: ZeroSuicide.com

- http://zerosuicide.sprc.org/about/research-articles-outcomes/outcome-stories
- http://zerosuicide.sprc.org/organizational-self-study
- http://zerosuicide.sprc.org/champions/implement-zero-suicide
Contact Information

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Jgoldstein@edc.org

Suicide Prevention Resource Center
www.SPRC.org

ZERO Suicide in Health and Behavioral Health Care
www.ZeroSuicide.com
Henry Ford Health System’s
Zero Suicide Initiative

Brian K. Ahmedani, PhD
Director, Center for Health Policy & Health Services Research
Henry Ford Health System
July 2019
Details about Henry Ford

- **Henry Ford Health System (HFHS)**
  - Large health system serving southeast- and mid- Michigan, including the Detroit metropolitan area.
    - 8 hospitals and >40 medical centers.
  - Full range of services:
    - Primary care, outpatient medical specialties, inpatient, and emergency.
    - Behavioral health services, including a stand-alone psychiatric hospital, a chemical dependency treatment center, additional inpatient services, partial hospitalization, and outpatient care.
  - Serves >1 million patients per year.
The Henry Ford Story

- Institute of Medicine Report: “Crossing the Quality Chasm”
- RWJ Grant Opportunity Finalist
  - Application for ‘Perfect Depression Care’ in Behavioral Health Services department at HFHS
- “Blues Busters” Team
  - Senior leadership, physicians, other clinical staff, and patient advisors.
- Zero Suicides becomes the goal; Expanded to all conditions (not just depression).
- Expansion into primary care and other medical settings.
The Evolution of Zero Suicide

- Started at Henry Ford…
- The research evolved throughout the 2000s.
- National Action Alliance formed to create a new National Strategy – Focus on Zero Suicide.
- Zero Suicide adopted by Substance Abuse and Mental Health Services Administration (SAMHSA).
- Resources made available by Suicide Prevention Resource Center (SPRC).
- International Zero Suicide movement begins.
Care Redesign

- High Reliability (Airline industry, 100% hand washing, zero infections).
- Map out a “perfect” delivery of care model that fits within your resources and staffing
  - Universal vs. Selective approaches.
    - High intensity treatments matched to those at greatest risk, while low intensity approaches matched to those at lowest risk.
  - Use creativity and plan for changes.
- Policies and procedures must support this model.
- The care model must be integrated into work flow.
- The care model must be integrated into your EMR.
The Care Pathway

- Screening, risk stratification.
- Suicide risk assessment and safety plan.
- Level of risk determines the treatment / intervention, via evidence-based approaches (CBT / DBT).
- Strong family involvement.
- Means reduction protocol reviewed at every visit.
- Train entire team on the model and clinical approaches.
- Focus on access and engagement.
- Rapid cycle quality improvement.
Suicide Rates at Henry Ford

*Improvement in other outcomes as well.
Key Takeaways / Current Grant

- The program was associated with a significant reduction in suicide mortality among our patient population.
- Ongoing quality improvement is paramount.
  - E.g., expansion into primary care after recognizing many patients were never reaching behavioral health.
- Our current research grant from the National Institutes of Health will allow us to examine which care pathways best prevent suicide and suicide attempt across 6 large health systems and >9 million patients per year (Grant # U01MH114087).
Roundtable Discussion
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  ▪ Share how your organization is working to achieve Healthy People goals

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